CSSA ACCIDENT REPORT FORM

Date	Time	Carnival & Venue	School

Surname	Given Name	Date of Birth	Gender
			M F

Address	City	State	Postcode

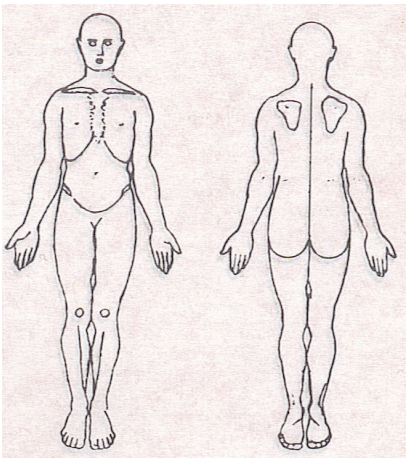
History of Accident / Injury

Allergies	Medication

Observations	Time	Time	Time
Level of Consciousness			
Fully Conscious *Drowsy* *Unconscious*			
Pulse			
Rate *Description*			
Breathing			
Rate *Description*			
Skin			
Colour			
Other Observations			

Assessment

Abrasion
Burn
Contusion
Deformity
Fracture
Haemorrhage
Laceration
Pain
Rigidity
Swelling
Tenderness



Assessment

Treatment

Follow Up / Referral	Comments
☐ Ambulance	
☐ Medical Centre	
☐ Own Doctor	
☐ Other	

First Aider (Print):			
Signature:	Date:	Time:	1. Original to CSSA President 2. Copy to First Aider 3. Copy to Patient/Doctor/Ambulance

Please complete **"Accident Report Form"** within 24 hours of incident and email to:
CSSA Executive Officer: Linda Heslehurst E: linda@cssa.nsw.edu.au M: 0418 685 898