CSSA ACCIDENT REPORT FORM

Date	**Time**	**Carnival & Venue**	**School**

Surname	**Given Name**	**Date of Birth**	**Gender**
			M **F**

Address	**City**	**State**	**Postcode**

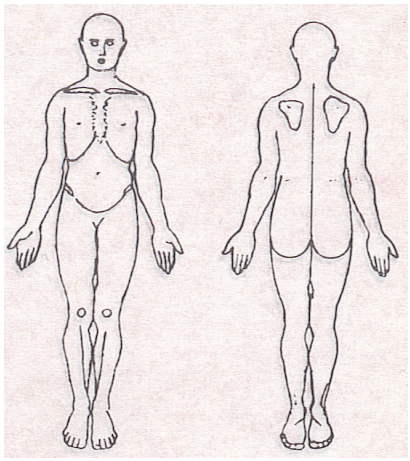
History of Accident / Injury

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.net.au M: 0418 685 898