

First Aid Treatment and/or Referral Report

Campout _____ Location _____

Date of Incident _____ Time _____ AM ___ PM ___

Camper's Name _____
(Parents' if a minor)

Address _____ Phone _____

_____ Zip Code _____

Describe the Reason for Request _____

Describe Treatment and/or Assistance Given _____

Further Treatment and/or Assistance Suggested _____

Was person referred to a doctor and/or hospital? Yes _____ No _____

Was person transported to hospital? Yes _____ No _____

If yes, by ambulance _____ committee member's car _____ camper's car _____

Whose car? _____ Other _____ What _____

Signed _____
(Patient or responsible adult) (First Aid Committee Member)

Date _____