FIRST AID TREATMENT RECORD
ADM. 53b

This form needs to be completed when a Member requires first aid treatment.

1 PARTICIPANT'S DETAILS

Participant's Name	DOB	Membership No.

2 MEDICATION DETAILS

Date/Time	Presenting Issue (ie rash/asthma/seizure)	Treatment provided & medication taken (if needed)	Follow-up completed	First Aid provider's initials

3 FOLLOW UP

If first aid treatment was provided, have the parents/guardians been notified? ☐ **NO** ☐ **YES** › *Indicate when & how:*

Was a Girl Guide Incident Report completed? ☐ **NO** ☐ **YES** › *Completed on:* *Submitted to:*

Name of First Aider	Signature	Date

If a Girl Guide Incident report was completed please attach a copy of this first aid treatment record.

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2 MEDICATION DETAILS

Date/Time	Presenting Issue (ie rash/asthma/seizure)	Treatment provided & medication taken (if needed)	Follow-up completed	First Aid provider's initials

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