

First Aid Form – School and Parent Record



Holy Eucharist School is a school which operates with the consent of the Catholic Archbishop of Melbourne and is owned, operated and governed by Melbourne Archdiocese Catholic Schools (MACS), where formation and education are based on the principles of Catholic doctrine, and where the teachers are outstanding in true doctrine and uprightness of life.

Student Name: _____

Class: _____ Date: _____ Time: _____

Staff Member's Name: _____

Location with the school: _____

Does the student have a medical plan? Y/N

If yes, please consult the **Special Health Needs Booklet** _____

The student received first aid attention for the following reason

- | | |
|---|--|
| <input type="checkbox"/> Insect Sting or bite | <input type="checkbox"/> Received knock/blow to the head |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Heavy knock or bruising to body |
| <input type="checkbox"/> Complained of abdominal pain | <input type="checkbox"/> Received cut/abrasion which caused distress |
| <input type="checkbox"/> Complained of earache | <input type="checkbox"/> Complained of headache |
| <input type="checkbox"/> Bad cold | <input type="checkbox"/> Complained of toothache |
| <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Complained of chest pain |
| <input type="checkbox"/> Had an asthma attack | <input type="checkbox"/> Suffered from diarrhoea |
| <input type="checkbox"/> Had rash/sores | <input type="checkbox"/> Nosebleed |
| <input type="checkbox"/> High temperature | <input type="checkbox"/> Complained of sore throat |
| <input type="checkbox"/> Other reason: _____ | |

The student received the following treatment

- | | |
|---|---|
| <input type="checkbox"/> Received First Aid at school | <input type="checkbox"/> Parent/carer contacted by telephone |
| <input type="checkbox"/> Allowed to rest and returned to class | <input type="checkbox"/> Attempted to contact parent/carer (message left) |
| <input type="checkbox"/> Taken to outpatients at local hospital | <input type="checkbox"/> Collected by parent/carer |
| <input type="checkbox"/> Ambulance called | |

Additional comments, e.g. witnesses to incident etc:

Name: _____

Date and Time: _____ Signed: _____

Copy for Parent and original to be kept at school on file.