Chirurgeon Injury Report Form

Event_______________________________ Group____________________________ Date __ /__ /____

Consent: I have been informed of the training level of the treating chirurgeon(s) and hereby give consent for □ Myself/ □ My Child to be treated:

Patient/Guardian Sig:____

Refusal: I have been informed of the training level of the treating chirurgeon(s). I understand that first aid has been recommended for □ Myself/ □ My child which I refuse. I understand that it is my responsibility to seek appropriate medical care. I release the chirurgeon(s) and all SCA authorities from any and all liability for any ill effects that may result from my decision to refuse aid.

Patient/Guardian Sig:____

Please Print All Information

Legal Name Time of incident □ Adult □ Child

____

SCA Name ____

Guardian Legal Name____

Address____

□ Trauma___________ □ Illness__________□ M__ □ F D.O.B.__/__ /__

Phone(___)___________________________ Recurring Injury______ □ Y___ □ N

Allergies: ____

Medications: ____

Medical History: ____

Injury Type □ Kitchen _____ □ Dancing _____ □ Combat _____ □ Camping _____□ Other______

If combat: □ Single □ Melee

Injured by: □ weapon □ Terrain □ Armor □ Weather

If from weapon, type □ SS □ WS □ TW □ BS □ DGR □ PA □ Spear □ GS □ Cbt Arch □ Rapier □ Archery □ Unknown □ Other

Notes: ____

If Kitchen injury; type □ Cut □ Burn □ Crush □ Other

Notes: ____

____

Complaint: ____

Action Taken: ____

____

Advice Given: □ Ice □ Rest □ Fluids □ See Doctor □ Other

Attending Chirurgeon(s):

SCA Name Print Legal Name Signature Phone

____

____

____

____

C-I-C: ____

Vital Signs

Time__________ Respiration ______Pluse ___B/P___ L.O.C. ___R_ Pupils_ L___________ Temp

☐ Regular ☐ Regular ☐ Alert ☐ ☐ Normal
☐ Shallow ☐ Voice ☐ ☐ Dilated
☐ Labored ☐ Irregular ☐ Pain ☐ ☐ Constricted
☐ _______ ☐ Unresp ☐ ☐ Unresp

Time__________ Respiration ______Pluse ___B/P___ L.O.C. ___R_ Pupils_ L___________ Temp

☐ Regular ☐ Regular ☐ Alert ☐ ☐ Normal
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☐ _______ ☐ Unresp ☐ ☐ Unresp

Pt. will seek appropriate follow-up care_____________ Pt. Transported to facility________
Where___________________________________ By whom___________________________
Time left site_______________________________ How ______________________________
Comments/Progess/Additional treatment:
____
____
____
____
Notes/Comments/Addtional Names Relative to report:
____
____
____
____

Please mail to the Kingdom Chirurgeon with event report form.

THL Robert Marston
1219 Colfax St
Pittsburgh PA 15212