VAFR Medical/First Aid Treatment Form

When an injury occurs during a course or competition, individuals are required to report the incident immediately, and submit a completed VAFR Injury/Illness Report Form and attach this form.

Date: _____

Patient Information:		
Name:	**DOB:**	
Address:		
City:	**State:**	**Zip Code:**
Email:	**Phone:**	

Times:		
Injury Time:	**Patient Contact:**	**Patient Release/Transfer:**

Assessment:	
Signs/Symptoms:	**Allergies:**
Medications:	**Past Medical History:**
Chief Complaint:	
Physical Exam:	

Vital Signs:							
Time	**Mental Status**	**Pulse**	**Respiration**	**BP**	**Pupils**	**Pain Scale**	**Other**

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Treatment:
Treatment Provided:
Narrative:
Transport:
Was the patient transported by EMS? ☐ **Yes** ☐ **No** **Department:** _____

Provider Information:		
Name:	**Highest Certification Level:**	
Certification #:	**Certification Expiration Date:**	
Address:		
City:	**State:**	**Zip Code:**
Email:	**Phone:**	

I understand that the evaluation and treatment has been provided by Emergency Medical Services and not a physician. I understand a follow up medical evaluation and/or treatment should be completed by my doctor or at any hospital emergency department. I understand that if my condition worsens or does not resolve I will contact 911.

Patient or Guardian Signature: _____

Printed name, if not patient: _____ Date:_____

Provider Signature: _____

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