Program Leader Use - Form Sighted and Fully Completed ☐ Yes PL Initial ______

Reviewed and Updated: 25/11/05 PINK
This form must be returned to the Program Leader (with medical form) at the completion of the program

PA Incident Report Form

Please complete all sections of this form even if it doesn't appear relevant

Patient Name: ___________________________ D.O.B: ___/___/_____ M / F Student / Staff / PA Staff / Swinburne Student Cert IV / Dip

PA Group Code: ______ Venue: ______________________ Program Dates: ___________________________

Client Organization: _____________________________________ No. of Students: ________________________

School Representative: ________________________________ GL: ___________________________________

Other Staff (PA or other): __________________________________ Role:_______________________________

Temp (c) ______ Precipitation:(rain,snow,nil) ______________ Visibility:(good,fair,poor) ___________________

Type of Incident: **Date of Incident: ___/___/200__** **Time of Incident: _____________am/pm**
(Circle relevant box below)

☐ Injury
☐ Illness
☐ Behavioral
☐ Near Miss (serious injury narrowly avoided)
☐ Other (vehicle, equipment failure, etc)
____

Type of Injury or Illness (please **CIRCLE** the **primary injury or illness**, tick others that apply)

☐ N/A	☐ Blister	☐ Dental	☐ Gastrointestinal	☐ Psychological
☐ Abrasion	☐ Burn	☐ Dislocation	☐ Heat-Related	☐ Snakebite
☐ Anaphylaxis	☐ Cardiac	☐ Exhaustion	☐ Hypothermia	☐ Sprain
☐ Allergy, other	☐ Concussion	☐ Flu symptoms "cold"	☐ Laceration	☐ Strain
☐ Asthma	☐ Contusion	☐ Fracture	☐ Lightning	☐ Other _______
☐ Bite________	☐ Dehydration	☐ Frostbite	☐ Pre-existing	

Anatomical Location of Injury (please **CIRCLE** the **primary location**, tick others that apply)

☐ N/A	☐ Eye ☐ L ☐ R	☐ Hand/Fingers ☐ L ☐ R	☐ Lower Leg ☐ L ☐ R	☐ Toe ☐ L ☐ R
☐ Abdomen	☐ Face	☐ Head	☐ Neck	☐ Upper Arm ☐ L ☐ R
☐ Ankle ☐ L ☐ R	☐ Foot ☐ L ☐ R	☐ Hip ☐ L ☐ R	☐ Pelvis	☐ Upper Back ☐ L ☐ R
☐ Chest	☐ Forearm ☐ L ☐ R	☐ Knee ☐ L ☐ R	☐ Shoulder ☐ L ☐ R	☐ Wrist ☐ L ☐ R
☐ Elbow ☐ L ☐ R	☐ Genitalia	☐ Lower Back	☐ Thigh ☐ L ☐ R	☐ Other _______

Activity at Time of Incident (please **CIRCLE** the **primary activity**, tick others that apply)

☐ Abseiling	☐ Centre-Based	☐ Kayaking (Lake)	☐ Skiing (Alpine)	☐ Surfing
☐ Biking (Mountain)	☐ Cooking	☐ Rafting	☐ Skiing (Nordic)	☐ Swimming
☐ Biking (Street)	☐ Day Walking	☐ Raft Building	☐ Sledding	☐ Vehicle
☐ Bushwalking	☐ Initiatives	☐ Rock Climbing/Rappelling	☐ Sleeping	☐ Other _________________
☐ Campsite	☐ Inflatable Canoeing	☐ Ropes Course (High)	☐ Snowshoeing	
☐ Canoeing	☐ Kayaking (River)	☐ Ropes Course (Low)	☐ Snorkeling	

Primary Contributing Factor leading to Incident (please **CIRCLE** the **primary contributing factor**, tick others that apply)

☐ Animal Encounter	☐ Fall on rock	☐ Insect	☐ Psychological	☐ Other___________
☐ Carelessness	☐ Fall/Slip on Track	☐ Lack of Supervision	☐ Repetition	
☐ Cold Exposure	☐ Falling tree/branch	☐ Menstrual	☐ Rock Fall	
☐ Confrontation	☐ Fitness/ability	☐ Misbehavior	☐ Sunburn	
☐ Dehydration	☐ Hygiene	☐ Missing/ Lost	☐ Technical failure	
☐ Equipment	☐ Immersion/	☐ Not following instructions	☐ Technique	
☐ Exceeded Ability	☐ Instruction	☐ Motivation	☐ Unknown	

☐ Exhaustion ☐ Inattention ☐ Preexisting Condition ☐ Weather

Medication/Dressings Administered:
N.B. Patient's medical form **must be checked before any medication is administered.
You should only use medications from an approved PA First Aid kit.

Time	Date	Item Administered	Qty	Reason	Administered By:

Did patient leave group? ☐ Yes (please circle to where) Base Medical Facility Home Other ____________ ☐ No

If yes, did patient return to group? ☐ Yes - what date? ______________ ☐ No

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Narrative Summary of Incident: Please provide a brief objective description and clear picture of the incident (what happened and how, your response, the outcome). Use diagrams if appropriate. **Be sure to attach the patient's Medical Form with this document.**

____
____
____
____
____
____

Environmental conditions: (river level/road condition, etc.) ____

Exact location of incident: ____

Witness Section (Must be an adult, other than the person completing this form, closest to incident).

Witness Name: ________________________ Witness Signature: ____________________ Date: ____________

Witness Contact Address: ____

Relationship to Program: ____

Report Prepared By: ________________________Signature: _________________ Date: ____/____/200___

Medical Assistance Record - To be completed if treating medical professional is willing – If not, PL please check here ☐

Date of Visit: __/__/200__ Time of Visit: _________ am / pm Name and Location of Facility: ________________________

Name of Medical Professional:______________________________________ Qualification _________________________

Recommendation(s) from Medical Professional:

____
____
____
____

Can this patient continue with this program? ☐ Yes ☐ No Is there any additional medication required? ☐ Yes ☐ No

Is there any recommended change to the patient's daily routine whilst on program? ☐ Yes ☐ No
Detail ____

This section completed by: ______________________________ Date: ____________________________