

Troop 993 First Aid Encounter

Week	Date	Time	Scout	Campsite	Troop	Staff/Family	Staff Area
Patient Name:				Age	Temp	BP	Pulse
Area of camp where injury occurred:						Allergies	
Complaint:							
Assessment:							
<input type="checkbox"/> Arm <input type="checkbox"/>		<input type="checkbox"/> Leg <input type="checkbox"/> Left		<input type="checkbox"/> Foot <input type="checkbox"/> Right		<input type="checkbox"/> Hand	
<input type="checkbox"/> Abrasion <input type="checkbox"/> Blister <input type="checkbox"/> Bruise <input type="checkbox"/> Laceration <input type="checkbox"/> Sprain		<input type="checkbox"/> Bite/Sting <input type="checkbox"/> Homesickness <input type="checkbox"/> Poiso Ivy <input type="checkbox"/> Splinter <input type="checkbox"/>		<input type="checkbox"/> Allergies <input type="checkbox"/> Dehydarton <input type="checkbox"/> Stomach <input type="checkbox"/> Headache <input type="checkbox"/> Other			
Treatment:							
<input type="checkbox"/> Cleanse <input type="checkbox"/> TAO <input type="checkbox"/> Tinactin <input type="checkbox"/> Lozenges <input type="checkbox"/> Tylenol <input type="checkbox"/> Ibuprofen		<input type="checkbox"/> Bandage <input type="checkbox"/> Rest <input type="checkbox"/> Steroid Cream <input type="checkbox"/> Tums <input type="checkbox"/> Benadryl <input type="checkbox"/> Imodium		<input type="checkbox"/> Elevatin <input type="checkbox"/> Ice <input type="checkbox"/> Soak <input type="checkbox"/> Robitussin <input type="checkbox"/> Sudafed <input type="checkbox"/> Eye Drops			
Signature: _____							
Comments:							