

# Sample Medical Emergency Response Report

Date and time of report \_\_\_\_\_ Date and time of incident \_\_\_\_\_

Name of child \_\_\_\_\_

Location of emergency \_\_\_\_\_

What was the child's problem? \_\_\_\_\_  
\_\_\_\_\_

Did the injury or illness involve any of the following? (Check all that apply.)

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> CPR  | <input type="checkbox"/> An electric shock | <input type="checkbox"/> Hand (R) (L) |
| <input type="checkbox"/> Automated external defibrillation<br>(use of an AED) | <input type="checkbox"/> Burn              | <input type="checkbox"/> Foot (R) (L) |
| <input type="checkbox"/> Breathing assistance                                 | <input type="checkbox"/> Head              | <input type="checkbox"/> Poisoning    |
| <input type="checkbox"/> Bleeding   | <input type="checkbox"/> Eye (R) (L)       | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> A fall   | <input type="checkbox"/> Arm (R) (L)       | _____                                 |
|   | <input type="checkbox"/> Leg (R) (L)       | _____                                 |

What happened?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all responders who helped with the emergency  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What happened to the child? \_\_\_\_\_

Notified the child's parent/guardian \_\_\_\_\_

Notified the child's healthcare provider \_\_\_\_\_

Name of person completing report \_\_\_\_\_

Date \_\_\_\_\_