



First Aid Treatment Form

Event:

Date: / /

Time:

Sex: M F

Patient Name:

Patient

Age:

Location:

DoB:

Chief Complaint:

Allergies:

Medications:

LOC X 1 2 3 4

Job Code:

Practitioner Name:

Vitals

BP:

P:

Skins

BP:

P:

R:

R:

Disposition:	Code-4	Ambulance #	Parent	Self	AMA
Referred To:	_____				
Via:	_____				

Assessment

L R

REFUSAL OF TREATMENT/RELEASE FROM RESPONSIBILITY:

This is to certify that I release, waive, discharge, and covenant not to sue NATIONAL SPORTS MASSAGE & ATHLETIC PRACTITIONERS®, LLC, and its Independent Contractors from the liability associated with my injuries and condition. I refuse further treatment even though I am informed and aware that my injuries may be serious and require further treatment. [] Patient Refused to Sign AMA

*Signature of Patient or Legal Guardian _____

Attending Signature: _____ Time Out: _____

[] ATC [] EMT [] PARAMEDIC