

## DCFS FIRST AID INFORMATION FORM

Bureau/Section:	Location:
Date:	Name of Injured:
Name of DCFS Safety Office or Person Attending to First Aid:	
Injured Person's Complaint:	
First Aid Treatment:	
Disposition of First Aid Recipient	
Returned to Work: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Sent for Medical Treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Activity at Time of Injury Event (If DCFS Employee) or Event Activity at Time of Injury Event (If Iberville Building Visitor):	
Equipment, Substance(s), and/or Material (s) Used in First Aid Treatment:	
Potential Severity: <input type="checkbox"/> Minor <input type="checkbox"/> Long Term <input type="checkbox"/> Disabling <input type="checkbox"/> Fatal	
Precautions which were taken, if any, to protect DCFS Safety Officer from Blood Borne Pathogens:	