

**Medical Team Incident Report**    Date \_\_\_\_\_ Time \_\_\_\_\_

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**D.O.B.** \_\_\_\_\_    **Home Phone:** \_\_\_\_\_

**Nature of Illness:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Heart Rate** \_\_\_\_\_

**Blood Pressure** \_\_\_\_\_

**Treatment Given:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies:** \_\_\_\_\_

**Past Medical History:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Transported to Hospital? No** \_\_\_ **Yes** \_\_\_ **By Car** \_\_\_ **Squad** \_\_\_

**Medical Team Member(s)** \_\_\_\_\_

\_\_\_\_\_