

Health Science Career Technology

EMT-Basic Course

Spring, 2009

This Packet Belongs To

If Found Contact Jim McKee, LP at 903.880.6125

EMS Internship Documentation Form

Name: _____

Address: _____

Social Security Number _____

Location: _____

EMT-B EMT-I EMT-P

Use separate form for Ambulance and Hospital Internship

Clinical Site or Ambulance Internship Site

A. _____

B. _____

C. _____

School Number: _____

Coordinator: _____

Clinical Area/Site	Date	Time In	Time Out	Number Of Hours	Description of Patient Management	Staff Signature

Total Hours This Sheet: _____ Total Hours All Sheets: _____ Coordinator's Signature: _____

EMS Internship Documentation Form

Name: _____

Address: _____

Social Security Number _____

Location: _____

EMT-B EMT-I EMT-P

Use separate form for Ambulance and Hospital Internship

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School Number: _____

Coordinator: _____

Clinical Area/Site	Date	Time In	Time Out	Number Of Hours	Description of Patient Management	Staff Signature

Total Hours This Sheet: _____ Total Hours All Sheets: _____ Coordinator's Signature: _____

Trinity Valley Community College EMS Program ~ Ambulance Internship Evaluation

Student Name: _____ EMS Unit/Station: _____ Date: _____

During ambulance internship, the student shall practice under the supervision of an Ambulance crew member.

Please evaluate each skill performed by the student according to the legend below.

Please mark all evaluations "n/a" if the skill was not attempted.

Evaluations of less than "2" require an explanation on the back of this form.

PLEASE FEEL FREE TO MAKE ANY COMMENTS CONCERNING THE STUDENT ON THE BACK OF THIS FORM.

ALL LEVELS			
Area of Evaluation	# of Skills	Evaluation	Comments
Professionalism		1 2 3 4 N/A	
Professionalism Appearance		1 2 3 4 N/A	
Initiative		1 2 3 4 N/A	
Overall Attitude		1 2 3 4 N/A	
Infection Control		1 2 3 4 N/A	
Interaction with Patient		1 2 3 4 N/A	
Interaction with Crew/Staff		1 2 3 4 N/A	
Scene Survey		1 2 3 4 N/A	
Present History		1 2 3 4 N/A	
Past History		1 2 3 4 N/A	
Vital Signs		1 2 3 4 N/A	
Breath Sounds		1 2 3 4 N/A	
Triage		1 2 3 4 N/A	
Physical Exam		1 2 3 4 N/A	
Control Bleeding		1 2 3 4 N/A	
Bandaging		1 2 3 4 N/A	
Splinting		1 2 3 4 N/A	
Traction Splint		1 2 3 4 N/A	
MAST Trousers		1 2 3 4 N/A	
AED		1 2 3 4 N/A	
CPR		1 2 3 4 N/A	
Bag-Valve-Mask		1 2 3 4 N/A	
Basic Airway Management		1 2 3 4 N/A	
Oxygen Therapy		1 2 3 4 N/A	
Spinal Immobilization		1 2 3 4 N/A	
Medication Administration		1 2 3 4 N/A	
Paramedic Clinical I, II, III			
Peripheral IV Insertion		1 2 3 4 N/A	
IV Piggy Back		1 2 3 4 N/A	
Draw Blood Sample		1 2 3 4 N/A	
Endotracheal Intubation		1 2 3 4 N/A	
IV Medication Administration		1 2 3 4 N/A	
IM Medication Administration		1 2 3 4 N/A	
SQ Medication Administration		1 2 3 4 N/A	
EKG Interpretation		1 2 3 4 N/A	
Defibrillation		1 2 3 4 N/A	
Cardioversion		1 2 3 4 N/A	
Pacing		1 2 3 4 N/A	
Needle Decompression		1 2 3 4 N/A	

Average Score: _____

Preceptor Signature: _____

Instructor Signature: _____

Crew Member Signature: _____

Student Signature: _____

Crew Member Name: _____

Date Submitted: _____

Legend:

1 – Rarely meets requirements;

2 – Meets some requirements;

3 – Meets and exceeds some requirements;

4 – Meets and exceeds most requirements;

N/A – Not applicable

Trinity Valley Community College EMS Program ~ Ambulance Internship Evaluation

Student Name: _____ EMS Unit/Station: _____ Date: _____

During ambulance internship, the student shall practice under the supervision of an Ambulance crew member.

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3 – Meets and exceeds some requirements;

4 – Meets and exceeds most requirements;

N/A – Not applicable

Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives:

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT: _____

BACK: _____

NEURO: _____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION: _____

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

Safety Devices: <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Airbag <input type="checkbox"/> Helmet <input type="checkbox"/> Seatbelt / Shoulder <input type="checkbox"/> Child Restraints	Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle <input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry <input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____	Damage to Vehicle: <input type="checkbox"/> N/A <input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover <input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior <input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage
---	---	---

Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Provided By: <input type="checkbox"/> 1 st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting <input type="checkbox"/> Bleeding Control	GCS / TS: GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____	Vitals: B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

Instructor Signature: _____ Date ___/___/___

Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives:

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT: _____

BACK: _____

NEURO: _____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION: _____

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

Safety Devices: <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Airbag <input type="checkbox"/> Helmet <input type="checkbox"/> Seatbelt / Shoulder <input type="checkbox"/> Child Restraints	Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle <input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry <input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____	Damage to Vehicle: <input type="checkbox"/> N/A <input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover <input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior <input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage
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Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Provided By: <input type="checkbox"/> 1 st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting <input type="checkbox"/> Bleeding Control	GCS / TS: GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____	Vitals: B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

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Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives):

HEENT: _____

NECK: _____

CHEST: _____

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EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION:

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

<p>Safety Devices:</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> None</p> <p><input type="checkbox"/> Airbag <input type="checkbox"/> Helmet</p> <p><input type="checkbox"/> Seatbelt / Shoulder</p> <p><input type="checkbox"/> Child Restraints</p>	<p>Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver</p> <p><input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian</p> <p><input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle</p> <p><input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry</p> <p><input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____</p>	<p>Damage to Vehicle: <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover</p> <p><input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior</p> <p><input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage</p>
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Student Signature: _____ Date ___/___/___

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Chief Complaint: _____

Past Medical History: _____

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Airway: _____ Breathing: _____ Circulation: _____

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CHEST: _____

ABD: _____

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TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

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Cords Visualized: Yes No Tube Size: _____

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Safety Devices: <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Airbag <input type="checkbox"/> Helmet <input type="checkbox"/> Seatbelt / Shoulder <input type="checkbox"/> Child Restraints	Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle <input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry <input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____	Damage to Vehicle: <input type="checkbox"/> N/A <input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover <input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior <input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage
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Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Provided By: <input type="checkbox"/> 1 st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting <input type="checkbox"/> Bleeding Control	GCS / TS: GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____	Vitals: B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

Instructor Signature: _____ Date ___/___/___

Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives:

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT: _____

BACK: _____

NEURO: _____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION:

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

<p>Safety Devices:</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> None</p> <p><input type="checkbox"/> Airbag <input type="checkbox"/> Helmet</p> <p><input type="checkbox"/> Seatbelt / Shoulder</p> <p><input type="checkbox"/> Child Restraints</p>	<p>Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver</p> <p><input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian</p> <p><input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle</p> <p><input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry</p> <p><input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____</p>	<p>Damage to Vehicle: <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover</p> <p><input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior</p> <p><input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage</p>
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<p>Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Provided By: <input type="checkbox"/> 1st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police</p> <p><input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED</p> <p>Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting</p> <p><input type="checkbox"/> Bleeding Control</p>	<p>GCS / TS:</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p>	<p>Vitals:</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p>
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

Instructor Signature: _____ Date ___/___/___

Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives):

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT: _____

BACK: _____

NEURO: _____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION:

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

<p>Safety Devices:</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> None</p> <p><input type="checkbox"/> Airbag <input type="checkbox"/> Helmet</p> <p><input type="checkbox"/> Seatbelt / Shoulder</p> <p><input type="checkbox"/> Child Restraints</p>	<p>Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver</p> <p><input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian</p> <p><input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle</p> <p><input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry</p> <p><input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____</p>	<p>Damage to Vehicle: <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover</p> <p><input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior</p> <p><input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage</p>
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<p>Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Provided By: <input type="checkbox"/> 1st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police</p> <p><input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED</p> <p>Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting</p> <p><input type="checkbox"/> Bleeding Control</p>	<p>GCS / TS:</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p>	<p>Vitals:</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p>
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

Instructor Signature: _____ Date ___/___/___

Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives:

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT: _____

BACK: _____

NEURO: _____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION: _____

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

Safety Devices: <input type="checkbox"/> N/A <input type="checkbox"/> None <input type="checkbox"/> Airbag <input type="checkbox"/> Helmet <input type="checkbox"/> Seatbelt / Shoulder <input type="checkbox"/> Child Restraints	Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle <input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry <input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____	Damage to Vehicle: <input type="checkbox"/> N/A <input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover <input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior <input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage
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Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Provided By: <input type="checkbox"/> 1 st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police <input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting <input type="checkbox"/> Bleeding Control	GCS / TS: GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____ GCS _____ TS _____ Time _____	Vitals: B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____ B/P _____ / _____ P: _____ (R I) R: _____ Time _____
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

Instructor Signature: _____ Date ___/___/___

Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives):

HEENT: _____

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CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT: _____

BACK: _____

NEURO: _____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION:

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

<p>Safety Devices:</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> None</p> <p><input type="checkbox"/> Airbag <input type="checkbox"/> Helmet</p> <p><input type="checkbox"/> Seatbelt / Shoulder</p> <p><input type="checkbox"/> Child Restraints</p>	<p>Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver</p> <p><input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian</p> <p><input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle</p> <p><input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry</p> <p><input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____</p>	<p>Damage to Vehicle: <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover</p> <p><input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior</p> <p><input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage</p>
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<p>Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Provided By: <input type="checkbox"/> 1st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police</p> <p><input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED</p> <p>Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting</p> <p><input type="checkbox"/> Bleeding Control</p>	<p>GCS / TS:</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p>	<p>Vitals:</p> <p>B/P ___/___ P: _____ (R I) R: _____ Time _____</p> <p>B/P ___/___ P: _____ (R I) R: _____ Time _____</p> <p>B/P ___/___ P: _____ (R I) R: _____ Time _____</p> <p>B/P ___/___ P: _____ (R I) R: _____ Time _____</p>
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

Instructor Signature: _____ Date ___/___/___

Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives):

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT: _____

BACK: _____

NEURO: _____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION: _____

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

<p>Safety Devices:</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> None</p> <p><input type="checkbox"/> Airbag <input type="checkbox"/> Helmet</p> <p><input type="checkbox"/> Seatbelt / Shoulder</p> <p><input type="checkbox"/> Child Restraints</p>	<p>Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver</p> <p><input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian</p> <p><input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle</p> <p><input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry</p> <p><input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____</p>	<p>Damage to Vehicle: <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover</p> <p><input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior</p> <p><input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage</p>
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<p>Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Provided By: <input type="checkbox"/> 1st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police</p> <p><input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED</p> <p>Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting</p> <p><input type="checkbox"/> Bleeding Control</p>	<p>GCS / TS:</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p>	<p>Vitals:</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p>
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

Instructor Signature: _____ Date ___/___/___

Chief Complaint: _____

Past Medical History: _____

Allergies _____

Description of Illness/Injury (Onset, Location, Duration, Quality, Radiating, Alleviating, Aggravating, Etc.): _____

INITIAL ASSESSMENT: (Description of Life Threatening Problems) LOC: A V P U ___ Appropriate ___ Inappropriate

Airway: _____ Breathing: _____ Circulation: _____

Focused Assessment: _____

On-going Assessment (Document all findings – positive and pertinent negatives):

HEENT: _____

NECK: _____

CHEST: _____

ABD: _____

PELVIS: _____

UPPER EXT: _____

LOWER EXT: _____

BACK: _____

NEURO: _____

SKIN: _____

ASSESSMENT: _____

TREATMENT: _____

EKG MONITORING: Rhythm: _____ HR _____ Ectopy Y / N

TIME	Treatment / Procedures / Meds / IV / O2	Results of Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

ENDOTRACHEAL INTUBATION:

Oral Nasal Equal B/S: Yes No Good Compliance: Yes No

Cords Visualized: Yes No Tube Size: _____

Reassessment En Route: _____

<p>Safety Devices:</p> <p><input type="checkbox"/> N/A <input type="checkbox"/> None</p> <p><input type="checkbox"/> Airbag <input type="checkbox"/> Helmet</p> <p><input type="checkbox"/> Seatbelt / Shoulder</p> <p><input type="checkbox"/> Child Restraints</p>	<p>Mechanism of Injury: <input type="checkbox"/> N/A <input type="checkbox"/> Auto <input type="checkbox"/> Driver</p> <p><input type="checkbox"/> Passenger <input type="checkbox"/> Ejected <input type="checkbox"/> Motorcycle <input type="checkbox"/> Pedestrian</p> <p><input type="checkbox"/> Electrocutation <input type="checkbox"/> Burn <input type="checkbox"/> GSW <input type="checkbox"/> Stab/P <input type="checkbox"/> Bicycle</p> <p><input type="checkbox"/> Farm <input type="checkbox"/> Crush <input type="checkbox"/> Fall _____ ft <input type="checkbox"/> Industry</p> <p><input type="checkbox"/> Home <input type="checkbox"/> Road / Highway <input type="checkbox"/> Other _____</p>	<p>Damage to Vehicle: <input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Steering Wheel <input type="checkbox"/> Windshield <input type="checkbox"/> Rollover</p> <p><input type="checkbox"/> Compartment <input type="checkbox"/> Major Damage Exterior</p> <p><input type="checkbox"/> Intrusion <input type="checkbox"/> Minor Damage</p>
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<p>Care Prior to Arrival?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Provided By: <input type="checkbox"/> 1st Responder <input type="checkbox"/> Fire <input type="checkbox"/> Police</p> <p><input type="checkbox"/> Citizen <input type="checkbox"/> Hospital / ED</p> <p>Type of Aid: <input type="checkbox"/> CPR <input type="checkbox"/> AED <input type="checkbox"/> Splinting</p> <p><input type="checkbox"/> Bleeding Control</p>	<p>GCS / TS:</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p> <p>GCS _____ TS _____ Time _____</p>	<p>Vitals:</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p> <p>B/P _____ / _____ P: _____ (R I) R: _____ Time _____</p>
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Preceptor Signature: _____ Date ___/___/___ Level EMT - EMT-I - EMT-P - LP - RN

Student Signature: _____ Date ___/___/___

Instructor Signature: _____ Date ___/___/___