SACRAMENTO FIRE DEPARTMENT CERT
MEDICAL TREATMENT FORM

Date: Time: Report #

Incident Location: Assigned CERT:

Patient Name: Age

Patient Address: DOB

City State Zip Male Female

Patient Phone ( ) DL/ID

Weight (Kg):

CHIEF COMPLAINT	VITALS					INITALS
	TIME	B/P	PULSE	RESP.	LOC.	

MEDICAL HISTORY	CURRENT MEDICATIONS (Rx, OTC & SUPPLEMENTS)
ALLERGIES	
TREATMENT CONSENT	**SIGNATURE:**
PARENTAL CONSENT	**SIGNATURE:**

EMR/EMT – B Tx	ASSESSMENT & TREATMENT NARRATIVE
M. D./NURSE/EMT - P TREATMENT	**MEDICATION, TREATMENT AND RESPONSE**

	Time	O2 Sat	Sugar	O2 LPM	Initial	
	Time	O2 Sat	Sugar	O2 LPM	Initial	

NAME	License, number, expiration date	