



TOWN OF VERNON FIRE DEPARTMENT

P. O. BOX 54
VERNON, CONNECTICUT 06066

NON-TRANSPORT RUNFORM

| | | | | |
|-------------------|------------|------|------------------------------|-----|
| LAST NAME | FIRST NAME | SEX | AGE | DOB |
| | | M F | | |
| ADDRESS | STREET | CITY | STATE | ZIP |
| RESPONSE LOCATION | | | P.S.A.P. NO. | |
| NARRATIVE | | | 1 ST RESP DISP | |
| | | | 1 ST RESP ARRIVAL | |
| | | | RUN NO. | |
| | | | INCIDENT DATE | |
| | | | DISPATCHED | |
| | | | RESPONDING | |
| | | | DEPARTING | |
| | | | INSERVICE | |
| | | | OFF THE AIR | |

THE FOLLOWING SERVICES ARE BEING REFUSED: _____

| | |
|---|-------------|
| <input type="checkbox"/> VITALS NOT TAKEN | |
| <input type="checkbox"/> VITALS ABSENT | GCS |
| TIME _____ | EYES _____ |
| B/P _____ | VERB _____ |
| PULSE _____ | MOTOR _____ |
| RESP _____ | TOTAL _____ |

This is to certify that I, _____

refuse emergency medical treatment or transportation to a medical facility by the Town of Vernon Fire Department/Ambulance. I am aware this is against the advice of the Town of Vernon Fire Department. I release the Town of Vernon Fire Department and its personnel from all responsibility for any and all ill effects which may result from this refusal. I understand that I can go for medical treatment at anytime on my own.

Signature _____

Parent / Legal guardian Signature _____

TVFD Member Signature _____ Witness Signature _____

| | | | | |
|--|------------|---|--|---|
| NATURE OF RUN | | SERVICE | | TRAUMA LEVEL 1 CRITERIA |
| <input type="checkbox"/> EMERGENCY <input type="checkbox"/> NON EMERGENCY | | <input type="checkbox"/> NOT REQ. <input type="checkbox"/> NOT FOUND | <input type="checkbox"/> REFUSED <input type="checkbox"/> CANCELLED | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| AMBULANCE SERVICE ID # | EMER VEH # | DRIVER | ATTENDENT | ATTENDENT |

FORM COMPLETED BY _____