**Key Points**

* **This assessment makes reference to the Purple Guide 2014.**
* **All event organisers must complete this assessment and return to the local authority event contact.**
* **All events are to have First – Aid regardless of size.**
* **Please note - a person holding a Health and Safety at Work, or a three day at Work Certificate does not qualify a person as competent to administer first aid to the public at events (as specified in the Purple Guide (2014) section 5.48)**

|  |  |
| --- | --- |
| Name of Event |  |
| Date and Time of Event |  |
| Name of the organisation providing your event with Medical/First Aid provision |  |
| Please document the name of the Medical Manager and their contact details on the day  |  |
| Projected size based on Purple Guide (2014) Section 5.114 |  |
| Has a Medical, Ambulance and First-Aid resource assessment been completed which complies with requirements of the Purple Guide (2014) Section 5.7? |  |
| Has a Medical Plan been completed which complies with the requirements of the Purple Guide (2014) section 5.15? |  |
| Please list medical equipment on site (e g Defibrillator) |  |
| If the event has taken place previously please provide the event medical report as specified in the Purple Guide (2014) section 5.109 and 5.110. |  |
| If the medical assessment identifies the need for an ambulance please provide the Care Quality Commission registration number as per the Purple Guide (2014) Section 5.12 |  |
| Who is the clinical lead on site? What is there clinical grade and role? |  |
| Please provide a map or plan of the site which complies with the Purple Guide (2014) Section 5.75 |  |
| Please provide details of the medical services communications plan as described in the Purple Guide (2014) Section 5.39 – 5.46.  |  |
| If assessed as required please provide a copy of the Handover of Responsibility document as described in the Purple Guide (2014) section 5.95 and 5.96. |  |
| Has the medical assessment taken into consideration the requirements of Annex 3 Adverse Weather Health Plan  |  |
| Will the private medical provider be conveying patients to acute care settings i.e.: Emergency Departments/ Minor Injury Units. If yes, are they aware of the local services and clinical networks and pathways?  |  |

Person Completing Assessment (Print) ……………………………………………………………………………….

Signature ……………………………………………………………………………...

Position/Role ………………………………………………………………………………

Date ………………………………………………………………………………