*The information that is provided on this form is strictly confidential and will only be used to assist the first aiders, paramedics, nurses and doctors in case of an accident or medical emergency while at work.*

Employee Details

|  |  |
| --- | --- |
| full name |  |
| dob |  |

Medical Contact Information

|  |  |
| --- | --- |
| doctors name |  |
| phone |  |
| private health cover | YES / NO | ambulance cover | YES / NO |
| do you suffer with any medical conditions? please list  |
|  |
|  |
| do you have any medication that needs to be administered if having a medical episode? if yes, please give details |
|  |
|  |
| do you have an allergy that is non medical? (bees, food) if yes, please give details |
|  |
|  |
| are you allergic to any medications? if yes, please give details |
|  |
|  |
| do you know your blood group? |  |
| please list any medications you currently take |
|  |
|  |

Emergency Contact Details

|  |  |
| --- | --- |
| full name |  |
| relationship |  |
| contact phone |  |

|  |  |
| --- | --- |
| full name |  |
| relationship |  |
| contact phone |  |

Signature of Employee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

*\*Please see a First Aid Officer if you need any assistance to fill in this form.*

*\*Office Use Only*

*To be reviewed every 6 months.*

|  |  |
| --- | --- |
| review date | status |
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