STAFF MEDICAL INFORMATION FORM

Please list below any information/medicines you feel would be needed by the emergency services should the need arise.

Staff Name: _____

Allergy or condition: _____

I agree to the following information being made available in my employment record for the information of the emergency services should the need arise.

Please give brief details of any serious ongoing condition as well as details regarding specific medication and its administration:

Doctor's details:

Name _____

Surgery/practice address _____

Telephone number _____

Signed _____