



Department	Document	Version	Creation Date	Last Revision
SFTY	SFTY.1.001	6	01.25.08	01.05.09
<b>VOLUNTARY PERSONAL MEDICAL INFORMATION SHEETS</b>				

Employer: \_\_\_\_\_

Please complete the requested information. Provide as much detail as possible. Medical information is confidential and can only be accessed by the medical team. The information you provide will precipitate your care in the event of an injury.

PERSONAL INFORMATION				
Name		Phone Number		
Address		City/Town		
Province/Territory	Area Code	Health Care/Card Number		
Date of Birth		Blood Type	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Next of Kin	Relationship	Contact Number		

MEDICAL INFORMATION	
Any current inoculations?	<input type="checkbox"/> Hepatitis B    + <input type="checkbox"/> Tetanus
Do you have Heart Disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have Diabetes?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2
Do you wear contact lenses?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have allergies?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please list your allergies and your reactions.</i>
Are you taking any medications that the first aid attendant should be aware of?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, please list:</i>
Name of drug	Dosage
Do you have any other medical conditions?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have any safety tickets (i.e., first aid, WHMIS, chainsaw)	
Signature	Date

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