EMERGENCY MEDICAL INFORMATION RECORD

Please complete, place in the envelope and store in the glove box of your vehicle.

The **confidential** information recorded below is for your protection and will only be accessed if you have been incapacitated by an incident that prevents **either you or your partner** from providing it.
In the event of you being incapable of talking coherently to a first aid person, and/or your partner is similarly incapacitated, the following record will assist the first aid person **to provide information to a doctor**, possibly by radio, for guidance on treatment. It may take some hours to retrieve and transport an injured person to hospital. In such circumstances first aid personnel and medical officers will require **as much information as possible** so that adequate treatment may be given without additional risk.

PERSONAL INFORMATION

FAMILY NAME …… GIVEN NAMES ……..

ADDRESS …… SUBURB / TOWN ……..

PHONE NUMBER / s…….. DATE OF BIRTH …../ …./……

AMBULANCE COVER NUMBER …… MEDICARE NUMBER ……..

MY DOCTOR …… PHONE No ……

NEXT OF KIN …….. PHONE No ……

EMERGENCY CONTACT NUMBERS

NAME …… PHONE No ……

NAME …… PHONE No ……

NAME …… PHONE No ……

NAME …… PHONE No ……

MEDICATION

Please list ALL medications you take, including herbal and other non-prescribed items.

DATE STARTED	MEDICATION NAME	DOSE	Morning	Midday	Evening	Before sleep

Continued over page

ALLERGIES

Are you allergic to any animal or insect bites? (e.g. Bee sting)	**Yes/ No**	If yes please describe:
Band aids and/or elastoplast or similar bandages	**Yes/ No**	If yes please describe:
Medicines. (e.g. Aspirin, penicillin)	**Yes/ No**	If yes please describe:
Foods (e.g. Gluten Products)	**Yes/ No**	If yes please describe:
Other	**Yes/ No**	Please describe:

MEDICAL CONDITIONS

High Blood Pressure	**Yes/ No**	Comment:	Epilepsy	**Yes/No**	Comment:
Heart disease	**Yes/ No**	Comment:	Asthma	**Yes/No**	Comment:
By-pass surgery	**Yes/ No**	Comment:	Diabetes	**Yes/No**	Comment:
Pacemaker	**Yes/ No**	Comment:	Emphysema	**Yes/No**	Comment:
Migraine	**Yes/ No**	Comment:			

OTHER MEDICAL CONDITIONS:

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IMMUNISATION STATUS

Immunisation	Tetanus **Y / N**	Influenza **Y / N**	Pneumonia **Y / N**	Other ……...
Date of last booster				

Where, in your vehicle, do you keep your medications that are required for a current medical condition?

…….

SIGNED: …….. DATE: ……/……/……