University of Galway, Safety Office

First Aid Record Form

DETAILS OF PERSON WHO RECEIVED FIRST AID:

Name: _____ Date of Birth: _____

Unit: _____ Gender: M/F _____

Is the person a: ☐ University Employee – specify their occupation: _____

☐ Student ☐ Visitor ☐ Contractor ☐ Member of the Public

DETAILS OF INCIDENT:

Date _____ time _____ (am/pm) and location _____ of incident requiring first aid treatment.

What was the nature of the incident requiring treatment ? (e.g. a chemical splash/cardiac arrest)

_____

What treatment was given ? (e.g. eye wash/C.P.R.)

_____

_____

_____

What happened to the person following first aid treatment ? (e.g. went to hospital)

_____

_____

_____

Any other details: _____

_____

_____

_____	_____	_____
Date	Name of First Aider/Other person providing treatment	Signature

Immediately on completion send original to Safety Office, University of Galway.

In the case of an accident, please complete University of Galway Accident Report Form instead.