KINGAROY COURIERS
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Employee Medical Information

First Name:

Address: Suburb:

State:

Date of Birth:

Emergency Contact:

Emergency Contact Phone Number:

Are you currently taking, or in the past 2 years required any prescribed medication? Yes ☐ No ☐

If yes Provide further details:

Do you have any known allergies? Yes ☐ No ☐

If Yes provide further details:

Are you taking or do you require medication for known allergies? Yes ☐ No ☐
If yes provide further details

Tick if you have suffered from/been diagnosed with/or suffering from;

☐ Asthma	☐ Severe Hay fever	☐Migraines
☐ Heart Disease	☐ Blood Pressure	☐ Heart Attack
☐ Bleeding Disorders	☐ Nerve Damage	☐ Arthritis
☐ Back Injury	☐ Hernia	☐ Diabetes
☐ Thyroid Problems	☐ Epilepsy	☐ Fainting
☐ Fits	☐ Vision problems not able to be corrected	
☐ Hearing loss	☐ Nervous Disorders	☐ Phobias
☐ Serious ligament damage		

☐ Any other issues that may prevent or hinder you from performing your role, or any conditions that the workplace needs to know about to ensure a safe workspace for all employees and stake holders.

If any of the above is checked please provide further details below (medications required, severity, date range if previous)