

Student Name: _____



Work Experience Emergency Details

The purpose of this form is to record details essential to ensure the safety and wellbeing of students attending our clinic for work experience. Details provided in these forms are strictly confidential and are only used for your safety and emergency purposes.

Students under 18 years of age must complete this form and obtain the signature of a parent/guardian.

Student Details:

First Name: _____ Surname: _____

Date of Birth: _____ Student: YES / NO (Please Circle)

Training Provider: _____

Contact name: _____ Contact Number: _____

Emergency Contacts:

1. Contact name: _____ Relationship: _____

Contact numbers: _____ or _____

2. Contact name: _____ Relationship: _____

Contact numbers: _____ or _____

Medical Information:

Do you have any chronic illness, disease or pre-existing injury that may affect your duties at Canberra Equine Hospital? YES / NO Details: _____

Do you have any disabilities (learning, mental, physical)? YES / NO
Details: _____

Do you have any allergies or adverse drug reactions? YES / NO
Details: _____

Are there any immediate treatments you require should you have an allergic reaction or suffer an acute episode of your disease or condition? YES / NO
Details: _____

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____