# 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 email form to HealthSafetyTeam@universityofgalway.ie**

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