FEMA US&R RESPONSE SYSTEM - Task Force Medical Team **CONFIDENTIAL!**

MEDICAL CHECK-IN	1. INCIDENT NAME	2. DATE PREPARED	3. TIME PREPARED	

4. MEDICAL HISTORY (TO BE COMPLETED BY TF MEMBER - DISCLOSURE DOES NOT NECESSARILY PRECLUDE DEPLOYMENT)

NAME: TF POSITION:

MEDICAL CONDITIONS: ☐ ASTHMA ☐ CHF ☐ DIAB ☐ HTN ☐ PSYCH ☐ ORTHO ☐ OTHER (EXPLAIN)
☐ CARDIAC ☐ COPD ☐ GI/GU ☐ PACEMKR ☐ OB/GYN ☐ SEIZ

ALLERGIES:

CURRENT MEDICATIONS/ DOSE:

VACCINATIONS: (<5 YEARS) ☐ TETANUS ☐ DIP ☐ HEP B ☐ OTHER

MEDS WITH YOU: ☐ ADEQUATE ☐ INADEQUATE

SPARE CORR. LENSES? YES ☐ NO ☐

BLOOD TYPE:

DO YOU NOW OR HAVE YOU IN THE PAST SUFFERED FROM ANY OF THE FOLLOWING?:

YES	NO		YES	NO		YES	NO	
☐	☐	DIZZINESS/ FAINTING	☐	☐	IRREGULAR HEARTBEAT	☐	☐	JOINT PAIN
☐	☐	BLURRED VISION	☐	☐	HIGH BLOOD PRESSURE	☐	☐	RASH/ SKIN CONDITION
☐	☐	MIGRAINE HEADACHES	☐	☐	EXERCISE INTOLERANCE	☐	☐	FEAR OF CONFINED SPACES
☐	☐	NOSE BLEEDS	☐	☐	ABDOMINAL PAIN	☐	☐	FEAR OF HEIGHTS
☐	☐	DIFFICULTY EQUALIZING EARS	☐	☐	NAUSEA/ VOMITING	☐	☐	PANIC/STRESS REACTION
☐	☐	RESP. INFECTION/ CONGESTION	☐	☐	DIARRHEA	☐	☐	DIFFICULTY SLEEPING
☐	☐	SORE THROAT	☐	☐	RECTAL BLEEDING	☐	☐	DEPRESSION
☐	☐	FEVER	☐	☐	URINARY TRACT INFECTION	☐	☐	FOOD INTOLERANCES
☐	☐	CHEST PAIN/ DISCOMFORT	☐	☐	MUSCOSKELETAL INJURIES	☐	☐	MOTION SICKNESS

HAVE YOU BEEN EXPOSED IN THE LAST 72 HOURS TO ANY PERSON SUFFERING FROM THE FOLLOWING?:

YES	NO		YES	NO		YES	NO	
☐	☐	FEVER	☐	☐	RESP. INFECTION/ CONGESTION	☐	☐	OTHER COLD/FLU-LIKE SYMPTOMS
☐	☐	SORE THROAT/ COUGH	☐	☐	NAUSEA/ VOMITING	☐	☐	SKIN RASH

5. EMERGENCY CONTACT INFORMATION (ALL INFORMATION WILL BE KEPT IN STRICT CONFIDENCE.)

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____

PHONE: ( ) - _____ ALT. PHONE: ( ) - _____

ADDRESS: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

PERSONAL PHYSICIAN:

NAME: _____ PHONE: ( ) - _____

ADDRESS: _____ (STREET) _____ (CITY) _____ (STATE) _____ (ZIP)

WORKER'S COMP/OTHER INFO

EMPLOYEE NUMBER: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ DATE OF HIRE: _____

RELIGIOUS AFFILIATION: _____ DRIVER'S LICENSE #: _____

NAME:

(CONTINUED ON BACK)

6. PHYSICAL ASSESSMENT (TO BE COMPLETED BY MEDICAL DIRECTOR OR DESIGNEE)

A. VITAL SIGNS (IF NEEDED)

TIME	PULSE	REPS	B/P	TEMP	SAO_2	EKG	COMMENTS
			/		%		
			/		%		

B. EXAM/SURVEY

	WNL	ABN	COMMENTS
NEURO	☐	☐	
HEAD	☐	☐	
NECK	☐	☐	
CHEST	☐	☐	
LUNGS	☐	☐	
ABD	☐	☐	
BACK	☐	☐	
PELVIS	☐	☐	
EXTREM	☐	☐	

ADDITIONAL INFORMATION:

CONDUCTED BY: | SIGNATURE:

8. MEDICAL DEPLOYMENT RECOMMENDATION

☐ ACCEPT ☐ REJECT ☐ DEFER | REASON:

ACTION TAKEN:

MED TEAM MNGR (NAME): | SIGNATURE:

TF LEADER ACTION TAKEN:

TF LEADER (NAME): | SIGNATURE:

ADDENDUM? ☐ YES ☐ NO