POD Staff Medical Screening Form

Name:_____ Date: ___ /___ /____

Cell Phone: ( ) _____ Home Phone: ( ) _____ Email: _____

Municipal/Agency Affiliation (if applicable): _____

Emergency Contact Information:

Name:_____ Cell Phone: ( ) _____

Relationship:_____ Home Phone: ( ) _____

PRE-DEPLOYMENT SCREENING (to be completed by team member)

The following questions regarding your health and physical condition are being asked to determine whether you have any limitations that may affect your ability to safely perform your duties during this deployment and to assist with your medical care during the deployment, should it become necessary. Answering affirmatively to any question will not necessarily disqualify you from service, so please answer all questions as fully and completely as possible. If you do not understand a question or are unsure how to respond, please discuss it with your screening provider or the incident Safety Officer.

Do you feel well today? YES_ _ NO_ _ If NO, please explain: _____

Do you have *any restrictions* or difficulty in your ability to:					
	Yes	**No**		**Yes**	**No**
Sit for 1 hour or longer			Repetitively move any joint		
Stand for 1 hour or longer			Twist or move your wrist repetitively		
Bend or twist at the waist			Reach fully forward		
Bend or twist your neck			Kneel or squat		
Grasp forcibly for a sustained period			Walk rapidly		
Climb stairs or a ladder			Run		
Reach overhead			Jump		
Push or pull a load			Walk on an uneven surface		
Lift and put down a 10 pound load			Hear normal volume conversation		
Lift and put down a 25 pound load			Get up when seated in a chair without assistance		
Lift and put down a 50 pound load			Get up when seated on a floor without assistance		

Do you wear a medical alert bracelet or necklace? YES ____ NO _____

If you answered YES to any of the above, please explain: _____

_____

_____

Other restrictions:_____

Accommodations needed:_____

PLEASE READ: *I affirm that the information I have provided is complete and accurate to the best of my knowledge. I also hereby authorize the release of this medical information to emergency medical personnel to the extent it is needed, in the event I experience a medical emergency during this deployment.*

Signature: _____ Date: ___ /___ /____

POD Staff Medical Screening Form

Name: Municipal/Agency Affiliation:

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Does this team member have any restrictions? YES_____ NO_____

If YES, please explain: _____

_____

_____

_____

Screener Signature: _____ **Date:** ___ /___ /____

POST-DEPLOYMENT SCREENING (to be completed by team member at end of shift)

Do you feel well today? YES_ _ NO____ If NO, please explain: _____

Did you experience an injury or illness during this deployment? YES_ _ NO_ _

If yes, please describe the injury/illness, as well as where and how it happened: _____

_____

_____

_____

Did you report this incident to the Safety Officer or other official? YES_ _ NO_ _

If NO, why was it not reported? _____

Did you receive any on-site or off-site treatment for this injury or illness? YES_ _ NO____

If YES, please describe treatment: _____

PLEASE READ: *I affirm that the above information is complete and accurate to the best of my knowledge. I also affirm that I have been informed of appropriate procedures for reporting any injuries or illnesses that I may experience in the future that I feel may be related to my response activities today.*

Signature: _____ Date: ___ /___ /____

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Is a follow up needed for this team member? YES_____ NO_____

If YES, please explain: _____

_____

_____

_____

Screener Signature: _____ **Date:** ___ /___ /____