POD Staff Medical Screening Form

Name: _____ **Municipal/Agency Affiliation:** _____

Do you wear a medical alert bracelet or necklace? _____No _____Yes

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.*

Team Member Signature/Date: _____

OFFICIAL USE ONLY – to be completed by POD Staffing Coordination Team

Restrictions? _____Yes Explain: _____

_____ No _____

_____

Screener Signature/Date: _____

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

Do you feel well today?___ YES ____ NO (If not, why:_____)

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.*

Team Member Signature/Date: _____

Screener Signature/Date: _____

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Name: _____ Date: _____

Municipal or Agency Affiliation: _____

Contact Information:

Cell Phone: _____ Home Phone: _____

Email: _____

Emergency Contact:

Name: _____ Contact Numbers: _____

Relationship: _____ _____

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 not, why: _____)

Do you have *any restrictions* or difficulty in your ability to:

	Y	N		Y	N
Sit for 1 hour or longer			Repetitively move any joint		
Stand for 1 hour or longer			Twist or move your wrist repetitively		
Bend at the waist			Reach fully forward		
Twist at the waist			Kneel		
Turn your head			Run		
Bend or twist your neck			Jump		
Grasp forcibly for a sustained period			Squat		
Climb stairs or a ladder			Walk on an uneven surface		
Walk rapidly			Get up when seated in a chair		
Reach overhead			Get up when seated on a floor		
Push or pull a load			Hear normal volume conversation		
Lift and put down a 10 pound load			Other restrictions:		
Lift and put down a 25 pound load					
Lift and put down a 50 pound load			Accommodations Needed:		

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

_____

_____