

CONFIDENTIAL

Name _____ Unit of Affiliation _____

DR# _____ Assigned Function/Position _____ DSHR Member? Yes No

Please complete the information on the front side of this form before seeing the Disaster Health Services representative. Print all information. If not applicable, indicate by N/A. This information will be held in strict confidence.

1. Have you been seen by a physician or mental health professional in the last year? Yes No

If yes, please indicate:

When? _____ For What? _____
Released? Yes No

2. Describe any restriction on your activities. _____

3. List all medications used on a regular basis. _____

Do you have a minimum of a three-week supply with you? Yes No

4. Are you allergic to any medication? Yes No

If yes, list: _____

5. Do you have any other allergies such as dust, mold, bee stings, food, etc.? Yes No

If yes, list: _____

6. Date of last tetanus shot _____

7. Who should we contact in case of emergency?

Name _____

Relationship _____

Address _____ Phone _____

8. Permission is granted to contact my family physician in case of emergency. Yes No

Name _____ Phone _____

City/State _____

9. Insurance information:

Company _____ Phone _____

Group or policy # (if known) _____

Describe any special procedures your insurance company requires you to follow prior to seeking treatment.

Do we have your permission to contact your insurance company in case of emergency? Yes No

If this statement is incomplete or untrue, I understand my assignment may be terminated. I agree to report any accidents or health problems to Disaster Health Services or my supervisor. I understand that my own insurance will be used as coverage for illness and non-job-related injuries, and that I am ultimately responsible for any costs incurred.

Workers signature _____ Date _____

FOR COMPLETION BY DHS STAFF ONLY

Comments/Suggestions: _____

Required follow up: _____

This worker's assignment should be made with the following consideration: _____

DHS representative signature _____ Date _____

For Completion by DHS during Outprocessing Interview

Did the worker have any health problems or injuries while assigned to the relief operation? Yes No

If yes, describe: _____

Did the worker consult with DHS for this or any other reason? Yes No

Was a Health Record (Form 2077) completed? Yes No

Did the worker seek medical attention (other than from DHS)? Yes No

If yes, where and for what: _____

Did the worker miss any time while assigned to this relief operation? Yes No

If yes, how much: _____

How is the worker feeling today? _____

Does the worker need any follow-up care after returning home? Yes No

If yes, describe _____

Do any special arrangements need to be made for the worker's return home? Yes No

If yes, describe _____

If the worker is being released for health reasons:

Has the workers unit of affiliation been notified? Yes No

Has the workers family been notified? Yes No

Has the worker's compensation or general liability claim been filed for the worker? Yes No

If yes, has the worker been given insurance information? Yes No

Does the worker need to submit a medical release prior to his or her next assignment? Yes No

Does national headquarters need to review the appropriateness of future assignments? Yes No

Comments: _____

DHS representative signature _____ Date _____