



Health Status Record

CONFIDENTIAL

To be completed and signed by the individual, please PRINT all information

New

Annual

Change in health status

Name _____ DSHR # _____
Last First MI

Address _____ City _____ State _____ ZIP _____

Phone _____ Cell/alternate _____

Emergency Contact (Name) _____ Phone _____

Unit of Affiliation _____ Phone _____ Chapter Code _____

Group/Activity/Position 1. _____ 2. _____ 3. _____

Date of last Tetanus shot _____ Height _____ Weight _____ DOB _____

Allergies (food, medication, insect, dust, latex, etc.) What happens? What do you do?

Mark yes if you are able or no if unable, please explain any limitations or accommodations requested*

- Lift and carry 20 pounds repeatedly yes no _____
- Lift and carry 50 pounds repeatedly yes no _____
- Climb two or more flights of stairs yes no _____
- Stand for two hour periods yes no _____
- Sit for long periods yes no _____
- Walk on uneven terrain yes no _____
- Walk for two hours yes no _____
- Drive in daylight and at night yes no _____
- Bend and stoop yes no _____
- Sleep on a cot or floor yes no _____
- Work and live with little or no privacy yes no _____
- Tolerate extreme heat and humidity yes no _____
- Require air conditioning yes no _____
- Tolerate extreme cold yes no _____
- Tolerate areas with mold and mildew yes no _____
- Tolerate smoke or poor air quality yes no _____
- Require access to specialized medical care yes no _____
- Require electricity for medical devices/meds yes no _____
- Require assistance with health monitoring yes no _____
- Require special food items/diet/timing of meals yes no _____
- Tolerate exposure to mass casualties/death yes no _____
- Work 12 hour shifts/night/weekends yes no _____

*All accommodations must be requested in writing with supporting medical documentation.

Have you had any of the following conditions in the last 24 months?

- | | |
|---|--|
| <input type="checkbox"/> Heart attack/heart disease | <input type="checkbox"/> Bleeding disorders/ anticoagulation therapy |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke/CVA/TIA |
| <input type="checkbox"/> Migraines/headaches | <input type="checkbox"/> Anxiety/PTSD/Bipolar Disorder |
| <input type="checkbox"/> Skin problems/breaks in skin/lesions | <input type="checkbox"/> Seizures/nervous system/neurological |
| <input type="checkbox"/> Stomach/intestine/hernia | <input type="checkbox"/> Sleep apnea/sleep disorders |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Mobility issues |
| <input type="checkbox"/> Asthma/COPD/emphysema | <input type="checkbox"/> Back/joint/bone problems |
| <input type="checkbox"/> Vision problems (not corrected) | <input type="checkbox"/> Immune system problems |
| <input type="checkbox"/> Hearing problems/hearing aids | <input type="checkbox"/> Current infectious disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |

Any ER visits, hospitalizations, surgeries or ongoing therapy during the last 12 months?

List all prescription and routine over-the-counter medications and reason for taking.

MEDICATION:	HOW OFTEN:	REASON FOR TAKING:
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medical equipment or assistive devices used (crutches, canes, nebulizer, CPAP, oxygen, braces, wheelchair, service dogs, etc.).

I have reviewed the physical requirements for my group and activity in *Connection 2005-004, Review of Health Status Record* (on the Physical Capacity Grid) and the *DSHR System Handbook* with my unit of affiliation. I understand the physical requirements for being a disaster worker and hereby state that I am able to fulfill those requirements. I understand that if my health status changes, I am responsible for updating this form immediately and submitting to my unit of affiliation.

I understand that while health insurance is not required, I will be financially responsible for my health care expenses.

In signing below, I give permission for the Red Cross Staff Health Consultant or designee to contact my health care provider for information concerning my current health status. I will be notified before contact with my health care provider is made. I understand that refusal to sign may limit deployment.

Signature of DSHR Member _____ Date _____

Signature of Health Reviewer _____ Date _____