



Annual Medical Statement of Personnel

NOTE: This form is designed to provide the individual in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other employees. If any of the questions are answered "YES," be sure the answer is fully explained.

Questions:

Name: _____

Address: _____

City & State: _____ Zip: _____

Full Time Occupation: _____

Name of Organization: _____

Position/Title: _____

Social Security No. _____

What is your Valid State Operators Plate No. _____

REMARKS: If any question is answered, "YES," give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.

1. Birth Date: Month: _____ Day: _____ Year: _____

2. Eyesight:

| | Yes | No |
|---|--------------------------|--------------------------|
| a. Have you lost use of either eye? _____ R _____ L.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Is peripheral (side) vision restricted?.....b. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you color blind?c. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you have, or have you ever had, cataracts?.....d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Are actual deficiencies corrected by glasses or contact lenses?...e. | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Date of last eye examination:.....f. | | _____ |

3. Hearing:

| | | |
|---|--------------------------|--------------------------|
| a. Do you have difficulty hearing normal conversation level?.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you use a hearing aid?b. | <input type="checkbox"/> | <input type="checkbox"/> |

4. Diabetes:

| | | |
|--|--------------------------|--------------------------|
| a. Have you ever been treated for diabetes?a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Describe current medication and dosage, if any, and method of administration under "remarks." | | |
| c. Date of latest blood sugar test:c. | | _____ |

5. Heart:

| | | |
|---|--------------------------|--------------------------|
| a. Have you ever been treated for heart disease?a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Describe condition:.....b. | | _____ |
| c. Describe current medication and dosage, if any, under "remarks." | | |
| d. Do you have a pacemaker?d. | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Date of last treatment or check-up:e. | | _____ |

6. Epilepsy:

| | | |
|---|--------------------------|--------------------------|
| a. Have you ever been treated for epilepsy?.....a. | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when was your last seizure?.....b. | | _____ |
| c. Describe current medication and dosage, if any, under "remarks." | | |

Questions:

REMARKS:

- 7. Blood Pressure:**
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| a. Have you ever been treated for high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," when were you treated? | _____ | |
| c. What was your last reading? | _____ | |
| d. Describe current medication and dosage, if any, under "remarks." | | |

- 8. Limbs:**
- | | | |
|--|--------------------------|--------------------------|
| a. Have you lost an arm or leg? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you lost the use of an arm or leg?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Does vehicle have special controls? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If "Yes" to any of the above, describe under "remarks." | | |

- 9. Miscellaneous:**
- | | | |
|---|--------------------------|--------------------------|
| a. Have you ever had, or been treated for, Convulsions? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| c. Have you ever had any Fainting Spells? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| e. Have you ever had, or been treated for, Loss of Equilibrium?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| g. Have you ever been treated for Alcohol or Drug Abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |
| i. Have you ever been treated for Mental Illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If "Yes," give date of last treatment and describe current medication and dosage, if any, under "remarks." | | |

10. What is the date of your last physical examination? _____

11. Are there any restrictions posted on your vehicle operator's license?

12. Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle?

13. When and for what purpose, did you last consult a doctor?

14. Full Name, address and telephone number of your personal physician.

Name: _____

Address: _____

City & State: _____ **Zip:** _____

The answers to the above are complete, accurate, and true to the best of my knowledge.

Signature of Person Named Above

Date

Authorization For Release

"I hereby authorize any licensed physician, medical practitioner, hospital or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health, to give _____ Department/Company any such information."

A photographic copy, Xerox copy or similar reproduction of this authorization shall be as valid as the original.

Signature of Person Named Above

Date