DISASTER HEALTH INFORMATION

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 restrictions 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 medications**______________________
   ____
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 personal physician in case of emergency.** [ ] Yes [ ] No
   Name____ **Phone ( )**_______________________________
   City/State____
9. **Insurance information:**
   Name of 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 an 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.

Worker's signature____ **Date**______________________________

FOR COMPLETION BY DHS STAFF ONLY

Comments/Recommendations:____
____
____

Required follow-up:____
____
____

This worker's assignment should be made with the following considerations:____
____
____

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 the 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 worker's unit of affiliation been notified? [ ] Yes [ ] No

Has the worker's 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**____________________