Enhanced Pre-deployment Evaluation (to be completed by the Emergency Responder) [created by the ERHMS Workgroup]

Date: _____

Name: _____

Date of Birth: _____

Job Title: _____

Employer: _____

Job Location: _____

Please answer each of the questions to the best of your knowledge:

1. Health Status (pre-deployment)
    a. Pre-existing medical and mental health conditions: _____

    _____

    b. Past surgeries/dates: _____

    _____

2. Any Medical and/or Fitness concerns that you would like to be addressed

    _____

    _____

    _____

3. Medications you presently take:

    _____

    _____

    _____

    _____

4. Allergies (food, medicine, environmental):

    _____

    _____

_____

_____

5. Substances:
   e. Alcohol Use (Amount per day): _____
   f. Smoking (number of cigarettes per day): _____
   g. Other drugs or substances (amount per day): _____

6. Fitness Level:
   a. Height: _____inches
   b. Weight: _____
   c. BMI (to be determined by health care provider): _____
   d. Conditions that may impair your activities of daily living: _____

   _____

   e. Conditions that may limit your ability to perform strenuous activity:_____

   _____

   f. Score on most recent physical fitness test (if applicable):

      Score of _____out of a possible _____

7. Job-specific Risk Factors:

   a. Do your emergency response activities potentially require you to wear respiratory protection?

   Yes / No / Don't know

   b. Have you been fit-tested for an N95 respirator or other respiratory protection?

   Yes / No / Don't know

   c. Do your emergency response responsibilities involve the potential or exposure to hazardous substances? If yes, please describe: _____

   _____

8. Vision corrected_____and uncorrected_____

9. How is your hearing? Excellent / Good / Fair / Poor

10. Do you have a history of:

a. Chest pain? Yes /

No b. Syncope? Yes

/ No c. Abdominal pain?

Yes / No d. Seizure disorder?

Yes / No

e. Other medical / dental / or psychological conditions? Yes /
No

If yes, please describe: _____

_____

_____

11. Have you received the following vaccinations?

Vaccination	**Date last vaccination received (or date of final vaccination in series)**
For all responders	
Tetanus	
Hepatitis B	
Influenza	
Pandemic Influenza	
For selected responders	
Pneumococcal Vaccine	
Hepatitis A	
Measles/Mumps/Rubella	
Polio	
Varicella	
Rabies	
Anthrax	
Smallpox	

12. Describe any functional and/or access needs that you may have due to some form of disability.

_____

_____

To be completed by Agency / Organization / or Employer:

13. Exposure Anticipation:

    a. Anticipated deployment location (as specific as possible):

    _____

    _____

    b. Anticipated tasks to be performed (as specific as possible):

    _____

    _____

    c. Anticipated circumstances under which tasks will be performed (i.e., list of disaster types):

    _____

    _____

    d. Characteristics of expected work locations and relationship to known or suspected CBRN agents or conditions:

    _____

    _____

14. Anticipated date of deployment: _____

15. Anticipated duration of deployment: _____

16. Control anticipation:

    a. Anticipated need for PPE? Yes / No

    b. Anticipated type of PPE needed: _____

    _____

    c. Adequacy of pre-incident training for tasks? Yes / No

    d. Anticipated shift schedules: _____

    _____