Examples of Pre-deployment Screening Tools Used by Selected Emergency Response Units

Basic Evaluation

Interim Guidance for Pre-exposure Medical Screening of Workers Deployed for Hurricane Disaster Work

http://www.cdc.gov/niosh/topics/emres/preexposure.html

This document provides interim guidance on medical screening for workers before deployment to disaster response activities.

ROTC

http://college.vfmac.edu/LinkClick.aspx?fileticket=mlI8NoG3Z5c%3d&tabid=180

Very basic set of questions for a ROTC program.

Center for Domestic Preparedness Responder Screening Tool

http://www.emd.wa.gov/training/documents/Medical_Screening_FormCDP.pdf

Tool is used for responders under consideration for attendance at the Center for Domestic Preparedness, WMD Technical Emergency Response Training Course (TERT), WMD HAZMAT Technician Training Course (HT), WMD Hands-On Training Course (HOT), WMD Emergency Medical Services Course (EMS), WMD Emergency Responder Hazardous Materials Technician Course (ER HM), Agricultural Emergency Response Training, and the MCATI courses (CSM, HEC, BASIC, and PD).

Department of Defense Deployment Health Clinical Center - Form DD 2795

http://www.pdhealth.mil/dcs/pre_deploy.asp

The ***Pre-deployment Health Assessment Form (DD 2795)*** is a required form that allows military personnel to record information about their general health and share any concerns they have before deployment. It also helps healthcare providers identify issues and provide medical care before, during, and after deployment.

- DD 2795 is mandatory for deploying military personnel from every service, including reserve component personnel
- DD 2795 is to be completed and validated within the 30 days before deployment.

Enhanced Evaluation

Coast Guard Auxiliary Air Crew Screening Form

http://forms.cgaux.org/archive/a7042f.pdf

It may also be considered a Basic form, but it does go into disqualifying specific medical conditions, it has been placed in this section as an example of an Enhanced Form.

CDC Emergency Response Team Medical Clearance Guidelines (Hard copy is below)

This document was formulated to establish general guidelines for use in the medical evaluation and the fitness-for-duty clearance of applicants who volunteer to participate on the CDC-wide Emergency Response Team. It can represent an "enhanced" set of screening criteria used for those with responder duties that put them at moderate risk of injury and illness.

CDC Responder Readiness Medical Clearance

Name: _____Date: _____

Social Security Number: _____

The information you provide in this clearance exam is private and confidential.

Past Medical and Surgical History (List any past or current medical complaints, diseases, symptoms, surgeries, procedures or other conditions)

Date Condition Current Status

_____

_____

_____

_____

Family History (List any medical conditions of blood relatives including high blood pressure, heart or kidney disease, diabetes, cancer, alcoholism, psychiatric illness or others)

_____

_____

_____

_____

Social History

Do you use tobacco in any form? No Yes

Do you drink alcohol in any form? No Yes

Do you use illegal drugs or misuse other drugs? No Yes

Explain any "yes" answers. _____

_____

Assessment of Physical Activity Level (Describe type, amount and frequency of physical activity that you complete on a regular basis.) _____

_____

_____

Current Medications (Include prescription, over-the-counter, vitamins, supplements, herbals, others)

_____

_____

_____

_____

Allergies (List and describe medication, food, insect or other allergic reaction or adverse event)

_____

_____

_____

_____

_____

Name: _____ **Date:** _____

Immunization History (Give month and year when immunization(s) last completed if known)

Tetanus/Diphtheria _____

Hepatitis A _____

Hepatitis B _____

Measles/Mumps/Rubella _____

Varicella (if unknown, must titer) _____

Anthrax _____

Smallpox _____

TB Skin Testing _____

Review of Symptoms in Major Body Systems HAVE YOU EVER HAD:					
	YES	NO		YES	NO
1. Frequent or severe headaches?			26. Kidney or prostate disease?		
2. Dizzy spells, fainting or blackouts?			27. Diabetes?		
3. Epilepsy or seizures?			28. Thyroid disease?		
4. Eye trouble or vision problems?			29. Other endocrine disease?		
5. Ear problems or difficulty hearing?			30. Heavy menstrual bleeding?		
6. Hay fever or other allergies?			31. Anemia/hematological disorder?		
7. Dental problems?			32. Easy bruising or bleeding?		
8. Other ear, nose or throat problems?			33. Blood clots?		
9. Wheezing or asthma?			34. Arthritis/joint pains/swelling?		
10. Shortness of breath on exertion?			35. Other connective tissue disease?		
11. Chronic cough?			36. Joint or bone deformity/fracture?		
12. Coughing up blood?			37. Back pain; wear a back brace?		
13. Tuberculosis or (+) Tb skin test?			38. Difficulty walking?		

	YES	NO		YES	NO
14. Pain or pressure in your chest?			39. Eczema or atopic dermatitis?		
15. Palpitations or pounding heart?			40. Other rashes?		
16. Heart murmur?			41. Any other skin diseases?		
17. Other heart problems?			42. Cancer?		
18. High or low blood pressure?			43. Any immune system disorder?		
19. Frequent indigestion/heartburn?			44. Chronic steroid treatment?		
20. Stomach or intestinal problems?			45. Other immunosuppressive drugs?		
21. Hepatitis or liver disease?			46. Nerve injury or paralysis?		
22. Rupture or hernia?			47. A sleep disorder?		
23. Rectal bleeding or discharge?			48. Easy fatigability?		
24. Frequent urination?			49. Depression or crying spells?		
25. Kidney stones?			50. Other psychiatric problems?		

Give details of any "yes" answers above and comment on the current status of symptoms.

_____

_____

_____

List and describe any other medical problem, symptom, or concern not addressed above. _____

_____

_____

_____

For women only: Are you currently pregnant? **No Yes** Date of last menstrual period: _____

Name: _____ Date:_____

Please read and sign the following statement. If you feel you need additional information or have any questions regarding the medical risks of deployment or questions regarding the medical clearance process, please ask the CDC Occupational Health Clinic medical staff.

Deployment on a CDC/ATSDR emergency response team could involve physical and emotional stressors and hazards, including but not limited to:

- rapid deployment to any location upon short notice
- deployment lengths lasting weeks to months
- separation from family and friends
- personal security issues
- sleep deprivation, time zone changes, and irregular sleep schedules
- irregular quality, availability, and variety of meals
- exposures to extremes of climate and altitude
- limited availability of immediate medical care
- lack of refrigeration or electricity for medications, medical supplies, or equipment
- increased physical demands related to prolonged standing, walking, or exertion
- routine use of personal protective equipment such as respirators and protective clothing
- possible exposure to infectious organisms, chemical, or radiologic agents
- risk related to allergy, adverse events or side effects from medications, vaccines, or other required pharmaceutical interventions
- for pregnant women, possible risk to a developing fetus

I have read the above medical questionnaire and statements. I have answered all questions accurately and to the best of my knowledge. I realize that further information or testing may be needed from my private physician or other sources to clarify my fitness for this duty. I know of no condition which would impair my ability to function fully on a CDC emergency response team now or for the following two years.

Signature_____ Date_____

You may STOP here. The clinic staff and physician will complete the remainder of this form

Name:_____Date:_____ TO BE COMPLETED BY PHYSICIAN:				
Height_____	Weight_____	Pulse_____	BP_____	Distant vision: R 20/___ L 20/___ Corrected? Y N

CLINICAL EVALUATION Check each item as indicated. Enter 'NE' if not evaluated	Normal	Abnormal	Notes or Other Comments
1. Skin			
2. Head and neck (thyroid)			
3. Ear, nose, and throat			
4. Lymph nodes			
5. Eyes (include fundoscopic)			
6. Lungs			
7. Breast			
8. Heart			
9. Abdomen			
10. Genitalia (if indicated)			
11. Rectal exam (if indicated)			
12. Vascular system			
13. Extremities and spine			
14. Neurological			
15. Psychiatric (specify any significant cognitive, mood or behavioral observations)			

Comprehensive Evaluation

NFPA 1582 Chapter 6 Medical Evaluations of Candidates

http://www.nfpa.org/aboutthecodes/list_of_codes_and_standards.asp?cookie%5Ftest=1
http://www.cortlandcountyfire.org/NFPA%201582.pdf

This document provides a detailed list of the medical conditions that could impact the ability of a fireman to safely perform essential job tasks. It can be used as an example of the type of "comprehensive" questions that could be used for a screening exam for those responders who face serious hazards and risks when responding to emergencies, such as those faced by firefighters.

USCG Medical Manual CIM 6000.1C

http://www.uscg.mil/directives/listing_cim.asp?id=6000-6999

This is a very comprehensive program aimed to cover all operations of USCG Personnel, ranging from air crewmen and marine vessel inspectors to pollution and emergency responders. There is a basic form that all personnel fill out, and then, for each specific hazards to which the member may be exposed, there is a form geared specifically for those hazards (e.g., asbestos, benzene, noise).

Department of Defense Deployment Health Clinical Center - Form DD 2795

http://www.pdhealth.mil/dcs/pre_deploy.asp

The ***Pre-deployment Health Assessment Form (DD 2795)*** is a required form that allows military personnel to record information about their general health and share any concerns they have before deployment. It also helps healthcare providers identify issues and provide medical care before, during, and after deployment.

- DD 2795 is mandatory for deploying military personnel from every Service, including Reserve Component personnel, and
- DD 2795 is to be completed and validated within the 30 days prior to deployment.

American Red Cross

These documents are used by the American Red Cross to assess their volunteer's health status before deployment. (Not available online; hard copies are attached below.)

- **Health Status Record**: Self assessment of physical abilities, medical issues, and medications filled out by the volunteer and updated yearly
- **Health Status Record Review Summary Sheet**: Administrative assessment completed by the RN or MD from the unit after reviewing the Health Status Record from the volunteer
- **Pre-assignment Health Questionnaire**: Checklist filled out by the unit deploying the volunteer including several health questions asked to the volunteer immediately prior to deployment to assess if there has been a change in health status since the completion of the Health Status Record
- **Physical Capacity Grid**: Matrix that lists the potential disaster deployment roles and the physical requirements for each

American Red Cross

Health Status Record

CONFIDENTIAL

To be completed and signed by the individual. Please print all information

☐ **New** ☐ **Annual Update** ☐ **Change in Health Status**

If this is an Annual Update, is there a change in:

☐ **Health Status** ☐ **Address** ☐ **Phone No.** ☐ **E-mail Address** ☐ **Contact Information**

Name: _____ DSHR # _____
Last First MI

Address: _____
Street City State ZIP

Phone: _____
Home Cell Work

E-mail Address: _____

Emergency Contact: _____
Name Phone Relationship

Unit of Affiliation: _____
Chapter Name Phone Chapter Code

Group/Activity/Position: _____ _____ _____
First Second Third

Mark *Yes* if you are able and *No* if not able and *explain* any limitations under "Limitation Explanations" below (all accommodations must be requested in writing with supporting medical documentation)**:**

☐ yes ☐ no	Lift and carry 20 lbs multiple times per shift	☐ yes ☐ no	Speak clearly on phone and in person
☐ yes ☐ no	Lift and carry 50 lbs multiple times per shift	☐ yes ☐ no	Read small print for extended periods
☐ yes ☐ no	Stand for two-hour periods	☐ yes ☐ no	Work for long periods on a computer
☐ yes ☐ no	Sit for two-hour periods	☐ yes ☐ no	Climb two or more flights of stairs
☐ yes ☐ no	Walk on uneven terrain	☐ yes ☐ no	Drive in daytime and at night
☐ yes ☐ no	Walk two miles during a shift	☐ yes ☐ no	Work/live in areas with mold/mildew
☐ yes ☐ no	Bend or stoop multiple times during a shift	☐ yes ☐ no	Work/live in areas with smoke/poor air
☐ yes ☐ no	Crawl on floor or ground	☐ yes ☐ no	Work/live with little or no privacy
☐ yes ☐ no	Work outdoors in inclement weather	☐ yes ☐ no	Sleep on the floor or a cot
☐ yes ☐ no	Work in extreme heat and/or humidity	☐ yes ☐ no	Travel by any type of transportation
☐ yes ☐ no	Work in extreme cold	☐ yes ☐ no	Work 12 hr shifts/nights/weekends
☐ yes ☐ no	Able to step up/down 18 inches	☐ yes ☐ no	Work productively during change/stress
☐ yes ☐ no	Spend hours writing		
Mark Below Yes if Required or No if Not Required			
☐ yes ☐ no	Electricity for medical devices/meds	☐ yes ☐ no	Assistance with health monitoring
☐ yes ☐ no	Special food or timing of meals	☐ yes ☐ no	Air conditioning for health reasons
☐ yes ☐ no	Access to specialized medical care		

Limitation(s) Explanations:

_____

Date of last Tetanus shot (Within 10 years is considered up to date)**:** _____

Height: _____ **Weight:** _____ **DOB:** _____

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

_____

In the last 12 months, have you been diagnosed with/continued treatment for any of the following?

☐ yes ☐ no	Heart attack/heart disease	☐ yes ☐ no	Bleeding disorders/anticoagulation therapy
☐ yes ☐ no	High blood pressure	☐ yes ☐ no	Stroke/CVA/TIA
☐ yes ☐ no	Migraines/frequent headaches	☐ yes ☐ no	Mental Health (Anxiety/PTSD/Bipolar)
☐ yes ☐ no	Skin problems/breaks in skin/lesions	☐ yes ☐ no	Seizures/nervous system/neurological
☐ yes ☐ no	Stomach/intestine/hernia	☐ yes ☐ no	Sleep apnea/sleep disorders
☐ yes ☐ no	Urinary problems	☐ yes ☐ no	Problems walking, moving
☐ yes ☐ no	Asthma/COPD/emphysema	☐ yes ☐ no	Back/joint/bone problems
☐ yes ☐ no	Vision problems (Not corrected)	☐ yes ☐ no	Immune system problems
☐ yes ☐ no	Hearing problems/hearing aids	☐ yes ☐ no	Infectious disease
☐ yes ☐ no	Diabetes	Other:	

Explain '**yes**' items above**:**

Any ER visits, hospitalizations, surgeries or ongoing therapy during the last 12 months? ☐ **yes** ☐ **no**
If yes, explain and include dates**:**

Please list all prescription and over-the-counter medications, and reason for taking:

MEDICATIONS	HOW OFTEN	REASON FOR TAKING

List all medical equipment or assistive devices used (crutches, canes, nebulizer, CPAP, oxygen, braces (arm/leg), wheelchair, service animals, etc.):

I have reviewed the physical requirements for my group and activity in *Connection 2006-028, Deploying a Healthy Workforce* and the *DSHR System Handbook* (with addendums) 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 Reviewer 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.

My typed signature/date is verification that information on this form is correct. Please sign form if faxing.

Signature of DSHR Member: _____ **Date:** _____

Signature of Health Reviewer: _____ **Date:** _____

Codes-Hardship/Restriction: _____

HSR Review Summary Sheet	**ARC Use Only**
Place in the following DSHR Member's personnel health file	
Name:	
DSHR Number:	
Date HSR Completed: *{Must be completed yearly}*	
Reviewed By:	
Title:	
Date Reviewed:	

ARC Hardship Codes; Check all that apply:

☐ **None**	☐ **C7 Working Conditions**
☐ **C1 Water Disruption**	☐ **C8 Limited Health Care**
☐ **C2 Power Outage**	☐ **C9 Extreme Emotional Stress**
☐ **C3 Limited Food Availability**	☐ **C10 Travel Conditions**
☐ **C4 Extreme Heat and/or Humidity Limitation**	☐ **C11 Transportation**
☐ **C5 Extreme Cold**	☐ **C12 Air Quality**
☐ **C6 Housing Shortages**	☐ **C13 Lifting Limitation**

Place the Hardship Code information in the DSHR System database under "Restriction Information".

☐ **RH Restricted Hardship, note codes checked above**
☐ **RM Restricted Medical**
☐ **TI Temporarily Inactive**

Comments:	

Pre-Assignment Health Questionnaire

This form is to be filled out by the person at the unit of affiliation that is responsible for DSHR deployment or their designee. If the unit should not have deployed the member based on their DSHR record, they may be charged for the member's travel.

Member Name _____DSHR# _____ Requested for DR# _____

1 Does the member have a current *Health Status Record* on file? Yes_____No_____**If no, have member complete Health Status Record before continuing**.

2 Does the member have a medical restriction (RM) on their DSHR profile? Yes_____No_____**If yes, do not recruit. The RM needs to be resolved first.**

3 Verify any hardship codes associated with the relief operation. Does the member's DSHR record include any of the hardship codes associated with this relief operation? Yes___No___**If yes, do not recruit without clearance from the Chapter Health Reviewer. If the chapter does not have a Health Reviewer, the Division Health Consultant must be notified to review the information prior to assignment and deployment.**

Read the following statements to the member: "Do not give me any health information. Give me yes or no answers. If you fail to give accurate information and are not able to serve as recruited on the relief operation for health reasons, the Red Cross may request reimbursement for your travel."

1 Are there any requirements for your group/activity/position on the Physical Capacity Grid that you cannot meet? (Chapter recruiters may need to read the requirements to the member). Yes____No_____

2 Do you currently have any stitches or areas of broken skin? Yes____ No_____

3 Do you currently have a cast, brace or other device that restricts movement? Yes__ No____

4 Do you currently use a cane or other device to assist you? Yes____ No____

5 Have you been hospitalized or seen in the ER in the past six months? Yes__ No__

6 In the past three days, have you had any symptoms of illness such as fever >100 degrees, cough, sore throat, diarrhea, headache, flu -like symptoms etc.? Yes__ No_____

7 Has anyone in your immediate family had the flu or flu like symptoms (fever >100 degrees, cough, sore throat, diarrhea, headache within the past 7 days? Yes ____ No ___

8 Have you been around anyone with the flu or flu like symptoms (fever >100 degrees, cough, sore throat, diarrhea, headache in the past 7 days? Yes ___No ____

9 Have you traveled outside of your normal commuting area in the past 10 days? Yes ___Where? _____ No ___

10 Do you have any medical/laboratory tests scheduled within the next month? Yes__ No___

11 Have you started, changed or stopped any medications in the past 14 days? Yes____ No___

12 Will you need to refill any prescriptions during your assignment? Yes___ No___

If there are any "Yes" answers to these questions, the member must be approved by the Health Reviewer before deployment.

Name of person obtaining information _____Date _____

Name of Health Reviewer given the "yes" information above: _____

Retain this form in the member's DSHR file in case it is requested by Staff Health at national headquarters, the Division Staff Health Consultant or Staff Health on the relief operation.

Rev 4/09

DSHR Group / Activity		Physical Requirements																	
		Lift / carry 20 lb Muliple times/shift	Lift / carry 50 lb Muliple times/shift	Stand for two-hour periods	Sit for 2 hours periods	Walk on uneven terrain	Walk for two miles during a shift	Bend or stoop multiple time a shift	Crawl on the floor or ground	Work outdoors in inclement weather	Work in extreme heat and/or humidity	Work in extreme cold	Able to step up/down 18 inches	Spend hours writing	Speak clearly on phone and in person	Read small print for extended periods	Work for long periods on computer	Climb two or more flights of stairs	Drive in day time and at night
Operations Management	OM																		
Director	Dir	□		□	□	□				□	□	□		□	□	□	□	□	□
Assistant Director	AD	□		□	□	□				□	□	□		□	□	□	□	□	□
Multi-Site Diector	MD	□		□	□	□				□	□	□		□	□	□	□	□	□
Site Diector	SD	□		□	□	□				□	□	□		□	□	□	□	□	□
Individual Client Services	CLS																		
Client Casework	CC				□	□	□				□	□		□	□		□	□	□
Recovery Planning & Assistance	RPA													□	□		□	□	□
Disaster Health Services	HS	□		□	□	□	□	□		□				□	□	□	□	□	□
Disaster Mental Health	DMH	□		□	□	□	□	□		□				□	□	□	□	□	□
Mass Care	MC																		
Sheltering	SH	□		□	□			□			□	□			□				□
Feeding	FF	□	□	□	□	□	□	□		□	□	□	□		□			□	□
Bulk Distribution	BD	□	□	□	□	□	□	□		□	□	□	□		□			□	□
Safe & Well Linking	SWL	□		□	□	□	□	□			□	□		□	□	□	□	□	
External Relations	ER																		
Government Operations	LG			□	□	□	□								□	□	□	□	□
Community Partners	CPS	□		□	□	□		□		□	□	□			□		□	□	□
Public Affairs	PA			□	□	□	□	□		□	□	□		□	□	□	□	□	□
Fund Raising	FR			□	□									□	□		□		□
Information and Planning	IMS																		
Disaster Assessment	DA	□			□	□				□	□	□			□				□
Information Dissemination	ID			□	□		□							□	□	□	□	□	□
Financial & Statistical Info Management	FSI	□			□			□			□	□		□	□	□	□	□	□
Finance	FIN	□			□			□			□	□		□	□	□	□	□	□
Logistics	LOG																		
Facilities	FAC			□	□	□		□		□			□	□	□	□	□	□	□
In-Kind Donation	IKD				□									□	□	□	□	□	□
Warehousing	WHS	□	□	□	□	□	□	□		□	□	□	□	□	□	□	□	□	□
Transportation	TRA				□									□	□	□	□	□	□
Life, Safety and Asset Protection	LSAP	□		□	□	□	□			□	□	□			□		□	□	□
Procurement	PRO	□	□			□		□		□					□	□		□	□
Supply	SUP	□	□	□	□	□	□	□		□	□	□	□	□	□	□	□	□	□
Staff Services	SS																		
Local Community Volunteers	LCV	□		□	□			□						□	□	□	□	□	□
Staff Planning and Support	SPS			□	□			□						□	□	□	□	□	□
Staff Relations	SR			□	□										□				□
Staff Wellness	SW	□		□	□	□	□	□		□	□	□		□	□	□	□	□	□
Training	TR			□											□		□	□	□
Disaster Services Technology	DST																		
Computer Operations	RCO	□	□	□	□	□	□	□	□	□			□		□		□	□	□
Communication	RCM	□	□	□	□	□	□	□	□	□	□	□	□		□		□	□	□
Network	RNT	□	□	□	□	□	□	□	□	□	□	□	□		□		□	□	□
Customer Service	RCS	□	□	□	□	□	□	□	□	□			□	□	□		□	□	□

Revised 7-10

OSHA Respirator Medical Evaluation Questionnaire

The following link is where one can find the OSHA Respirator Medical Evaluation Questionnaire, which is contained in Appendix C of OSHA standard 1910.134 Personal Protective Equipment. http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9783