



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

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