



American Red Cross

Health Status Record

CONFIDENTIAL

To be completed and signed by the individual, please PRINT all information

New

Annual

Change in health status

Name DSHR #
Last First MI

Address City State ZIP

Phone Cell/alternate

Emergency Contact (Name) Phone

Unit of Affiliation Phone Chapter Code

Group/Activity/Position 1. 2. 3.

Date of last Tetanus shot Height Weight DOB

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

Mark yes if you are able or no if unable, please explain any limitations or accommodations requested*

Lift and carry 20 pounds repeatedly	yes	no	<input type="text"/>
Lift and carry 50 pounds repeatedly	yes	no	<input type="text"/>
Climb two or more flights of stairs	yes	no	<input type="text"/>
Stand for two hour periods	yes	no	<input type="text"/>
Sit for long periods	yes	no	<input type="text"/>
Walk on uneven terrain	yes	no	<input type="text"/>
Walk for two hours	yes	no	<input type="text"/>
Drive in daylight and at night	yes	no	<input type="text"/>
Bend and stoop	yes	no	<input type="text"/>
Sleep on a cot or floor	yes	no	<input type="text"/>
Work and live with little or no privacy	yes	no	<input type="text"/>
Tolerate extreme heat and humidity	yes	no	<input type="text"/>
Require air conditioning	yes	no	<input type="text"/>
Tolerate extreme cold	yes	no	<input type="text"/>
Tolerate areas with mold and mildew	yes	no	<input type="text"/>
Tolerate smoke or poor air quality	yes	no	<input type="text"/>
Require access to specialized medical care	yes	no	<input type="text"/>
Require electricity for medical devices/meds	yes	no	<input type="text"/>
Require assistance with health monitoring	yes	no	<input type="text"/>
Require special food items/diet/timing of meals	yes	no	<input type="text"/>
Tolerate exposure to mass casualties/death	yes	no	<input type="text"/>
Work 12 hour shifts/night/weekends	yes	no	<input type="text"/>

*All accommodations must be requested in writing with supporting medical documentation.

Have you had any of the following conditions in the last 24 months?

- | | |
|---|--|
| <input type="checkbox"/> Heart attack/heart disease | <input type="checkbox"/> Bleeding disorders/ anticoagulation therapy |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke/CVA/TIA |
| <input type="checkbox"/> Migraines/headaches | <input type="checkbox"/> Anxiety/PTSD/Bipolar Disorder |
| <input type="checkbox"/> Skin problems/breaks in skin/lesions | <input type="checkbox"/> Seizures/nervous system/neurological |
| <input type="checkbox"/> Stomach/intestine/hernia | <input type="checkbox"/> Sleep apnea/sleep disorders |
| <input type="checkbox"/> Urinary problems | <input type="checkbox"/> Mobility issues |
| <input type="checkbox"/> Asthma/COPD/emphysema | <input type="checkbox"/> Back/joint/bone problems |
| <input type="checkbox"/> Vision problems (not corrected) | <input type="checkbox"/> Immune system problems |
| <input type="checkbox"/> Hearing problems/hearing aids | <input type="checkbox"/> Current infectious disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |

Any ER visits, hospitalizations, surgeries or ongoing therapy during the last 12 months?

List all prescription and routine over-the-counter medications and reason for taking.

MEDICATION:	HOW OFTEN:	REASON FOR TAKING:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all medical equipment or assistive devices used (crutches, canes, nebulizer, CPAP, oxygen, braces, wheelchair, service dogs, etc.).

I have reviewed the physical requirements for my group and activity in *Connection 2005-004, Review of Health Status Record* (on the Physical Capacity Grid) and the *DSHR System Handbook* 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 Consultant or designee 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.

Signature of DSHR Member _____ Date _____