8181 Independence Blvd, Baton Rouge, La 70806

Physical Examination Form

The new applicant or current member of the Louisiana Urban Search & Rescue (LA US & R) is required to participate in US & R training, response, and or other related operational programs. A copy of the position description for this person's duty position, with a description of the duties required in that position must be attached to this form and should be reviewed by the examining physician prior to making a recommendation.

Nondiscrimination Policy: Louisiana Urban Search & Rescue does not discriminate on the basis of race, religion, age, color, creed, national or ethnic origin, sex, marital status, political affiliation or disability (except where disability may be a factor in the occupational qualifications).

Medical History Questionnaire

Name:	Sex: M F	Date:
Address:		
City:	State:	Zip:

Home Phone:	Work Phone:	Cell Phone:
Birth Date:		
Current Physician:	Phone Number:	Last Exam:

Medical History

Do you have any allergies to medications? ❑ No ❑ Yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

_____

List all major injuries, surgeries and/or hospitalizations you have had: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Are you pregnant and/or nursing? ❑ No ❑ yes

Do you wear glasses? ❑ No ❑ yes

Do you wear contact lenses? ❑ No ❑ yes

Review of Systems Do you currently, or have you ever had any problems in the following areas:

	NO	YES	?		YES	NO	?
CONSTITUTIONAL				EARS, NOSE, MOUTH, THROAT			
Fever, Weight Loss / Gain				Allergies /Hay Fever			
INTEGUMMENTARY (Skin)				Sinus Congestion			
NEUROLOGICAL				Runny Nose / Post-Nasal Drip			
Headaches				Chronic Cough			
Migraines				Dry Throat / Mouth			
Seizures				RESPIRATORY			
				Asthma			
Loss of Vision				Emphysema			
Blurred Vision				Chronic Bronchitis			
Distorted Vision / Halos				VASCULAR / CARDIOVASCULAR			
Loss of Side Vision				Diabetes			
Double Vision				High Blood Pressure			
Dryness				Heart Pain			
Mucous Discharge				Vascular Disease			
Redness				GASTROINTESTINAL			
Sandy or Gritty Feeling				Constipation			
Itching				Diarrhea			
Burning				GENITOURINARY			
Excess Tearing / Watering				Genital / Kidney / Bladder			
Foreign Body Sensation				SKELETOMUSCULAR			
Glare / Light Sensitivity				Rheumatoid Arthritis			
Eye Pain or Soreness				Muscle Pain			
Chronic Infection of Eye or Lid				Joint Pain			
Sties or Chalazion				LYMPHATIC / HEMATOLOGIC			
Flashes / Floaters in Vision				Anemia			
Tired Eyes				Bleeding Problems			
ENDOCRINE				ALLERGIC / IMMUNOLOGIC			
Thyroid / Other Glands				PSYCHIATRIC			

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

Patient's Signature **Date** **Doctor's Signature**

MEDICAL EXAM

NAME:	**DOB:**	**AGE:**	**DATE:**
Address:	**City:**	**State:**	**Zip Code:**
Urban Search & Rescue Position:	**Sponsoring Department/Agency:**		

ALLERGIES:

HEIGHT:	**WEIGHT:**	**BLOOD PRESSURE:**	**PULSE:**	**LMP:**

PROBLEMS ADDRESSED:
MEDICATIONS:
RXS WRITTEN:

Technical Standards

To ensure the safety and welfare of its members, Louisiana Urban Search & Rescue has established technical standards which must be met by the applicants and members.

_____

Physician: Please consider the following technical standards when answering question number four (4) in Part V of the physical form.

Yes	**No**	Sufficient Eyesight to conduct duties required by US & R duty position.
Yes	**No**	Sufficient Hearing to conduct duties required by US & R duty position
Yes	**No**	Sufficient gross and fine motor coordination to conduct duties required by US & R duty position.
Yes	**No**	Satisfactory physical strength and endurance to conduct duties required by US & R duty position.
Yes	**No**	Satisfactory intellectual and emotional functions to conduct duties required by US & R duty position.

Remarks: _____

_____

_____

_____

_____

_____

_____

Based on this limited examination, review of all attached pages I RECOMMEND:

_____ **The Applicant appears fit for operational; duties as described for their specified qualification**
_____ **The Applicant appears fit, but I would like this Medical valuation to be reviewed by the Urban Search & Rescue leader**
_____**The applicant is NOT cleared by me for Urban Search and Rescue related duties.**

Examiner Printed Name

Address _____

City _____ State/Zip _____

Phone Number _____

Reviewed: _____

Physician Signature

PHYSICIAN OFFICIAL STAMP or CARD HERE (required)

HIPAA AUTHORIZATION FORM

Patient's Full Name	**Patient's Social Security Number/Medical Record Number**
Address	**Patient's Date of Birth**
City, State Zip Code	**Patient's Telephone Number**

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:
   _____
2. The following person (or class of persons) may receive disclosure of protected health information about me:

   His/her/its Name

   Address

   City, State Zip Code
3. The specific information that should be disclosed is (please give dates of service if possible):

_____

_____

_____

UNLESS YOU SIGN HERE, NO INFORMATION ABOUT ALCOHOL/SUBSTANCE ABUSE, HIV/AIDS, OR MENTAL HEALTH WILL BE DISCLOSED:
YES, DISCLOSE THIS INFORMATION *_____
NO, **DO NOT** DISCLOSE THIS INFORMATION * _____

4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying _____ in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. My purpose/use of the information is for _____.
7. This authorization expires on _____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING – note that signature is required in two places.*

Signature of Individual* (The person about whom the information relates)	**Date of Individual's Signature**	**Date of Birth or Social Security Number**

OR, if applicable –

Signature of Guardian* or Personal Representative of Patient's Estate	**Date of Guardian's/Personal Representative's Signature**	**Description of Authority to Act for the Individual**

A copy of this completed, signed and dated form must be given to the Individual or other signator.

Official Use Only		
Received	**Processed By**	**Log #**