BENTON COUNTY
DEPARTMENT of EMERGENCY MANAGEMENT

Annual Medical Statement of Personnel

NOTE: This form is designed to provide the individual in charge of all personnel a complete history of physical status as of the date indicated without the need for expensive physical examinations. It is recommended that the form be completed on an annual basis by all drivers of emergency vehicles as well as other employees. If any of the questions are answered "YES", be sure the answer is fully explained.

Questions:

Name: _____

City & State: _____Zip: _____

Full Time Occupation: _____

Name of Organization: _____

Position/Title: _____

Social Security/ID #: _____

1. Birth Date: Month: _____ Day: _____ Year: _____

2. Eyesight:

		Yes	No
a.	Have you lost use of either eye? ___R ___L	☐	☐
b.	Is peripheral (side) vision restricted?	☐	☐
c.	Are you color blind?	☐	☐
d.	Do you have, or have you ever had contacts?	☐	☐
e.	Are actual deficiencies corrected by glasses or contact lenses?	☐	☐
f.	Date of last eye examinations: _____		

3. Hearing:

a.	Do you have difficulty hearing normal conversation level?	☐	☐
b.	Do you use a hearing aid? ____R ____ L	☐	☐

4. Diabetes:

a.	Have you ever been treated for diabetes?	☐	☐
b.	Describe current medication and dosage, if any, and method of administration under "remarks".		
c.	Date of last blood sugar test? _____		

5. Heart:

a.	Have you ever been treated for heart disease?	☐	☐
b.	Describe condition:_____		
c.	Describe current medication & dosage, if any, under remarks.		
d.	Do you have a pacemaker?	☐	☐
e.	Date of last treatment or check-up: _____		

6. Epilepsy:

a.	Have you ever been treated for epilepsy?	☐	☐
b.	If "Yes", when was your last seizure? _____		
c.	Describe current medication and dosage, if any, under remarks.		

Remarks:

NOTE: If any question is answered, "YES", give particulars below. For medical histories, underline the item and identify by referring to question number and letter. Give dates, symptoms, duration, treatment results, names and addresses of doctors, hospitals, etc.

Questions:	**Yes**	**No**	**Remarks:**
7. Blood Pressure:			
a. Have you ever been treated for high blood pressure?	☐	☐	
b. If "yes", when were you treated? _____			
c. What was your last reading? _____			
d. Describe current medication and dosage, if any, under remarks.			
8. Limbs:			
a. Have you lost an arm or leg?	☐	☐	
b. Have you lost the use of an arm or leg?	☐	☐	
c. Does your vehicle have special controls?	☐	☐	
d. If "yes" to any of the above describe under remarks.			
9. Miscellaneous:			
a. Have you ever had, or been treated for, convulsions?	☐	☐	
b. If "yes", give date of last treatment and describe current medication and dosage, if any, under remarks.			
c. Have you ever had and fainting spells?	☐	☐	
d. If "yes", give date of last treatment and describe current medication and dosage, if any, under remarks.			
e. Have you ever had, or been treated for, loss of equilibrium?	☐	☐	
f. If "yes", give date of last treatment and describe current medication and dosage, if any, under remarks.			
g. Have you ever been treated for Alcohol or drug abuse?	☐	☐	
h. If "yes", give date of last treatment and describe current medication and dosage, if any, under remarks.			
i. Have you ever been treated for mental illness?	☐	☐	
j. If "yes", give date of last treatment and describe current medication and dosage, if any, under remarks			
10. What is the date of you last physical examination? _____			
11. Are there any restrictions posted on your vehicle operator's license?	☐	☐	
12. Are you under the card of a physician for any other condition not mentioned above which may affect your ability to operate a motor vehicle?	☐	☐	
13. When and for what purpose did you last consult a doctor? _____ _____			
14. Full name address telephone number of your personal physician. Name:_____ Address: _____ City/State: _____Zip: _____			

The answers to the above are complete, accurate and true to the best of my knowledge.

_____ _____

Signature of Person Named Above **Date**

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital or medically related facility, insurance company, the Medical Information Bureau or other organization, institution, or person that has any records or knowledge of me or my health, to give Volunteer Firemen's Insurance Services, Inc any such information. Photographic copy, Zero copy or similar reproduction of this authorization shall be as valid as the original.

_____ _____

Signature of Person Named Above **Date**