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| **Annual Medical Statement Form 710** |
| **Christian County Citizen Corps** |

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.

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| Name |       | Address |       |
| City |       | State |       | Zip Code |  |
| Occupation: |       | Employer |       |
| Drivers License Number |       | Birth Date |       |
| Home Phone |       | Cell Phone |       |

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| **Eye Sight** |
| Have you ever lost use of either eye? | [ ]  Yes [ ]  No | Which Side?  |
| Is peripheral (side) vision restricted? | [ ]  Yes [ ]  No |       |
| Are you Color Blind? | [ ]  Yes [ ]  No |       |
| Do you have, or have you ever had cataracts? | [ ]  Yes [ ]  No |       |
| Are actual deficiencies corrected by glass or contacts? | [ ]  Yes [ ]  No |       |
| Date of last eye examination? | [ ]  Yes [ ]  No |       |
| **Hearing** |
| Do you have difficulty hearing normal conversation? | [ ]  Yes [ ]  No |       |
| Do you use a hearing aid? | [ ]  Yes [ ]  No |       |
| **Diabetes** |
| Have you ever been treated for Diabetes | [ ]  Yes [ ]  No |       |
| Describe current medication, dosage and method of administration. |       |
| Date of last blood sugar test | [ ]  Yes [ ]  No |       |
| **Heart** |
| Have you ever been treated for heart disease? | [ ]  Yes [ ]  No |       |
| Describe condition |  |
| Describe current medication, dosage  |       |
| Do you have a pacemaker? | [ ]  Yes [ ]  No |       |
| Date of last treatment and checkup? |       |
| **Epilepsy** |
| Have you ever been treated for Epilepsy? | [ ]  Yes [ ]  No |       |
| If Yes, when was your last seizure? |       |
| Describe current medication, dosage |       |
| **Blood Pressure** |
| Have you been treated for High Blood Pressure? | [ ]  Yes [ ]  No |       |
| If Yes, when were you treated? |       |
| What was your last reading? |       over       |
| Describe current medication & Dosage |       |
| **Limbs** |
| Have you lost an arm or leg? | [ ]  Yes [ ]  No |       |
| Have you lost the use of an arm or leg? | [ ]  Yes [ ]  No |       |
| Does your vehicle have special controls | [ ]  Yes [ ]  No |       |

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| **Miscellaneous** |
| Have you ever had, or been treated for Convulsions? | [ ]  Yes [ ]  No |       |
| Have you ever been treated for Loss of Equilibrium? | [ ]  Yes [ ]  No |       |
| Have you ever had any Fainting Spells? | [ ]  Yes [ ]  No |       |
| Have you ever been treated for Alcohol or Drug use? | [ ]  Yes [ ]  No |       |
| Have you ever been treated for Mental Illness? | [ ]  Yes [ ]  No |       |
| **Allergies** |
| Are you allergic to any Medications? |            |
| Anything else you are allergic to: |            |
| Do you carry an Epi Pen? | [ ]  Yes [ ]  No |
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| What is the date of your last physical examination |       |  |
| Are there any restrictions posted on your operator’s license? |       |  |
| When and for what purpose did you last consult a doctor? |       |
| Are you under the care of a physician for any condition not mentioned above which may affect your ability to operate a motor vehicle? |       |
| **Personal doctor information** |
| Name |       | Affiliation |       |
| Phone |       |

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

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 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 recorps or knowledge of me or my harm, to give the current Insurance Provider of Clever Fire and Rescue to give any such information, photographic copy, Fax, or similar reproduction of this authorization and shall be as valid as the original.

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 Signature of Person Named Above Date