# York County Fire School

## Medical/REHAB Evaluation Form

**All information pertained to this document will be held confidential unless you have a medical emergency**

**Date:** ______/______/______ **Date of Birth:** _____/_____/_____ **Age:** ______

**Name:** ____________________________________________

**Address:** ____________________________________________ **County:** ______________________________

____________________________________________

**Fire Department/Organization:** ______________________________________ **Stat. No:** ________

**EMERGENCY CONTACT INFORMATION**

**Name:** ____________________________________________ **Phone Number:** ______________________

**PAST MEDICAL HISTORY:**

________________________________________________________________________________________

________________________________________________________________________________________

**MEDICATIONS:**

________________________________________________________________________________________

________________________________________________________________________________________

**ALLERGIES:**

________________________________________________________________________________________

________________________________________________________________________________________

| | TIME | PULSE | B/P | RESPS | SPO2 | OK TO CONTINUE |
|---|---|---|---|---|---|---|
| **Baseline Vitals** | | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Vitals after each Evolution** | | | | | | |
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**Providers Name:** ____________________________________________ **PA DOH #:** ______________

**Providers Name:** ____________________________________________ **PA DOH #:** ______________

**PLACE ADDITIONAL INFORMATION ON BACK**

Developed 10/2010