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NORRISTOWN FIRE DEPARTMENT ANNUAL MEDICAL STATEMENT FOR APPARATUS OPERATORS

This form is designed to provide the Chief a complete history of physical status as of the date indicated without the need for a physical examination. This form shall be completed on an annual basis by all drivers of emergency vehicles. If any of the questions are answered "YES", be sure the answer is fully explained. The Municipality of Norristown reserves the right to have a member who has answered "YES" to any question to provide full documentation as to their fitness to operate borough owned emergency vehicles.

QUESTIONS:

Name: _____

Address: _____

City & State: _____ **Zip:** _____

Date of Birth: _____

Are you a: ☐ **Certified Operator** ☐ **Operator Candidate**

1) EYESIGHT:

a) Have you ever lost use of either eye? ☐ **Yes** ☐ **No**

b) Is peripheral (side) vision restricted)? ☐ **Yes** ☐ **No**

c) Are you color blind? ☐ **Yes** ☐ **No**

d) Do you have, or have you ever had cataracts? ☐ **Yes** ☐ **No**

e) Are actual deficiencies corrected by glasses or contact lenses? ☐ **Yes** ☐ **No**

f) Date of last eye examination _____

2) HEARING:

a) Do you have difficulty hearing normal conversation level? ☐ **Yes** ☐ **No**

b) Do you use a hearing aid? ☐ **Yes** ☐ **No**

DIABETES:

a) Have you ever been treated for diabetes ☐ **Yes** ☐ **No**

b) Please describe current medication and dosage, if any, and method of administration under "Remarks"

c) Date of latest blood sugar test _____

HEART:

a) Have you ever been treated for heart disease? ☐ **Yes** ☐ **No**

b) Please describe condition under "Remarks"

c) Do you have a pacemaker? ☐ **Yes** ☐ **No**

Date of last treatment or check-up _____

EPILEPSY:

a) Have you ever been treated for epilepsy? ☐ **Yes** ☐ **No**

b) If "Yes", when was you last seizure? _____

c) Describe current medication and dosage, if any, under "remarks"

6) BLOOD PRESSURE:

a) Have you ever been treated for high blood pressure? ☐ **Yes** ☐ **No**

b) If "Yes", when were you treated? _____

c) What was your last reading? _____

d) Describe current medication and dosage, if any, under "Remarks"

7) LIMBS

a) Have you lost an arm or leg? ☐ **Yes** ☐ **No**

b) Have you lost significant use of an arm or a leg? ☐ **Yes** ☐ **No**

c) Does vehicle have special controls? ☐ **Yes** ☐ **No**

d) If "Yes" to any of the above, please describe under "Remarks"

8) MISCELLANEOUS

a) Have you ever had, or been treated for convulsions? ☐ **Yes** ☐ **No**

b) If "Yes" please give the date of the last treatment and describe the current medication and dosage, if any, under "Remarks"

c) Have you ever had any Fainting Spells? ☐ **Yes** ☐ **No**

d) If "Yes", please 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? ☐ **Yes** ☐ **No**

f) If "Yes", please 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? ☐ **Yes** ☐ **No**

h) If "Yes", please give date of last treatment and describe current medication and dosage, if any, under "Remarks"

i) Have you ever been treated for mental illness? ☐ **Yes** ☐ **No**

j) If "Yes", please give date of last treatment and describe current medication and dosage, if any, under "Remarks"

REMARKS:

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. Attach additional paper and forms as necessary.

_____

_____

_____

_____

_____

WHAT IS THE DATE OF YOU LAST PHYSICAL EXAMINATION? _____

ARE THERE ANY RESTRICTIONS POSTED ON YOU VEHICLE OPERATOR'S LICENSE? ☐ **Yes** ☐ **No**

ARE YOU UNDER THE CARE OF A PHYSICIAN FOR ANY CONDITION NOT MENTIONED ABOVE WHICH MAY AFFECT YOU ABILITY TO OPERATE AN EMERGENCY VEHICLE? ☐ **Yes** ☐ **No**