

Lebanon 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						

Providers Name: _____

PA DOH #: _____

Providers Name: _____

PA DOH #: _____

PLACE ADDITIONAL INFORMATION ON BACK