

TF MEDICAL CHECK-IN	INCIDENT	Reporting Unit	ESF-9	Form US&R -	revised - 1/97
DISASTER#:	OPS PERIOD:	DATE/TIME PREPARED:	PREPARED BY:		
A. TO BE COMPLETED BY TF MEMBER AT TIME OF DEPARTURE					
Name:					
Team Position/Title:					
Present Medical Condition:					
Current Medications:					
On Hand: <input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate					
B. TO BE COMPLETED BY MEDICAL STAFF AT TIME OF DEPARTURE					
Physical Assessment					
Time:			Pulse:		
B/P:			Temp:		
Resp.:			Wt:		
HEENT Exam:					
Heart/EKG:					
Lungs:					
Abdomen:					
Extremities:					
Neurologic:					
Comments:					
Repeat Vitals (if indicated):					
Time:			Time:		
B/P:			B/P:		
Pulse:			Pulse:		
Resp.:			Resp.:		
EKG:			EKG:		
Temp:			Temp:		
C. MEDICAL DEPLOYMENT RECOMMENDATION					
Time:		Date:		<input type="checkbox"/> Accept <input type="checkbox"/> Reject	
Reason for rejection:					
Med Team Manager (print):			Signature:		
Action Taken:					
TFLeader (print)			Signature:		