YORK COUNTY PUBLIC SAFETY TRAINING CENTER

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

Edited 2/2025