



MABAS DIVISIONS 4 & 5 SRT

Hazardous Materials Medical Form

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

MEDICAL MONITORING

ENTRY GROUP NO: _____

ENTRY PERSONNEL

PRE-ENTRY

POST-ENTRY

Name	Temp	BP	Pulse	Resp	WT	Temp	BP	Pulse	Resp	WT
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

DECON GROUP NO: _____

ENTRY PERSONNEL

PRE-ENTRY

POST-ENTRY

Name	Temp	BP	Pulse	Resp	WT	Temp	BP	Pulse	Resp	WT
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

No personnel are allowed to don chemical protective equipment if their vital signs are found to be above the following:

Oral Temperature > 99.8

Blood Pressure > 150/90

Pulse > 110

Respiration > 25



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PRE-ENTRY GROUP DATA SHEET NO. _____

Duplicate sheet as needed. All sheets must be numbered.

Sheet _____ of _____

Entry shall be denied to any person with any of the following:

Oral Temperature > 100.6

Blood Pressure > 150/90

Pulse > 110

Respiration > 24

Medical Data

Name: _____	Name: _____
Dept: _____	Dept: _____
PRE-ASSIGNMENT	PRE-ASSIGNMENT
Vitals: _____	Vitals: _____
Temp _____ BP _____ Pulse _____ Resp _____	Temp _____ BP _____ Pulse _____ Resp _____
Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No Intials: _____	Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No Intials: _____
Reassigned: Staging _____ Other _____	Reassigned: Staging _____ Other _____

Medical Data

Name: _____	Name: _____
Dept: _____	Dept: _____
PRE-ASSIGNMENT	PRE-ASSIGNMENT
Vitals: _____	Vitals: _____
Temp _____ BP _____ Pulse _____ Resp _____	Temp _____ BP _____ Pulse _____ Resp _____
Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No Intials: _____	Approved: <input type="checkbox"/> Yes <input type="checkbox"/> No Intials: _____
Reassigned: Staging _____ Other _____	Reassigned: Staging _____ Other _____



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POST-ENTRY GROUP DATA SHEET NO. _____

Duplicate sheet as needed. All sheets must be numbered.

Sheet _____ of _____

Medical Data

Name: _____	Name: _____
Dept: _____	Dept: _____
POST-ASSIGNMENT	POST-ASSIGNMENT
Vitals: _____	Vitals: _____
Temp _____	Temp _____
BP _____	BP _____
Pulse _____	Pulse _____
Resp _____	Resp _____
Approved: _____	Approved: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intials: _____	Intials: _____
Reassigned: _____	Reassigned: _____
Rehab _____	Rehab _____
Other _____	Other _____

Medical Data

Name: _____	Name: _____
Dept: _____	Dept: _____
POST-ASSIGNMENT	POST-ASSIGNMENT
Vitals: _____	Vitals: _____
Temp _____	Temp _____
BP _____	BP _____
Pulse _____	Pulse _____
Resp _____	Resp _____
Approved: _____	Approved: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intials: _____	Intials: _____
Reassigned: _____	Reassigned: _____
Rehab _____	Rehab _____
Other _____	Other _____



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Entry Group Data

Name: _____	Name: _____
Level: _____ Suit No: _____	Level: _____ Suit No: _____
Suit Support (Name): _____	Suit Support (Name): _____
Suit Inspected Prior to Entry: <input type="checkbox"/> Yes <input type="checkbox"/> No	Suit Inspected Prior to Entry: <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Briefed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Time on Air: _____ PSI: _____	Time on Air: _____ PSI: _____
Time of Entry into Hot Zone: _____	Time of Entry into Hot Zone: _____
Time Left Hot Zone: _____	Time Left Hot Zone: _____
Notified Decon on Air: <input type="checkbox"/> Yes	Status Checks: 5 10 15 20 W

Entry Group Data

Name: _____	Name: _____
Level: _____ Suit No: _____	Level: _____ Suit No: _____
Suit Support (Name): _____	Suit Support (Name): _____
Suit Inspected Prior to Entry: <input type="checkbox"/> Yes <input type="checkbox"/> No	Suit Inspected Prior to Entry: <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Briefed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Time on Air: _____ PSI: _____	Time on Air: _____ PSI: _____
Time of Entry into Hot Zone: _____	Time of Entry into Hot Zone: _____
Time Left Hot Zone: _____	Time Left Hot Zone: _____
Notified Decon on Air: <input type="checkbox"/> Yes	Status Checks: 5 10 15 20 W

** This form must be completed by the Entry Group Supervisor and then given to the Medical Branch. **



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Hazardous Materials Medical Form

ENTRY / DECONTAMINATION GROUP DATA

Name: _____
Time in Suit/Entry: _____
Cylinder Pressure: _____
Time out of Hot Zone: _____
Cylinder Low Air Alarm: ☐ Yes ☐ No
Time Entered Decon: _____
Time out of Decon: _____
Full Decon: ☐ Yes ☐ No
Sent to Medical: ☐ Yes ☐ No

Name: _____
Time in Suit/Entry: _____
Cylinder Pressure: _____
Time out of Hot Zone: _____
Cylinder Low Air Alarm: ☐ Yes ☐ No
Time Entered Decon: _____
Time out of Decon: _____
Full Decon: ☐ Yes ☐ No
Sent to Medical: ☐ Yes ☐ No

* Move technician ahead if low alarm is sounding.

** If group re-enters the Hot Zone before complete decon, start a new form.

** This form must be completed by the Entry Group Supervisor and then given to the Medical Branch. **



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Hazardous Materials Medical Form

REHABILITATION EVALUATION FORM

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Type of Incident: _____ Group Commander: _____

	<u>Name</u>	<u>Department</u>	<u>Activity</u>	<u>Time In</u>	<u>Vitals</u>	<u>Time Out</u>	<u>Vitals</u>
1.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
2.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
3.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
4.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
5.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
6.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
7.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
8.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
9.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					
10.	_____	_____	_____	_____	_____	_____	_____
	Evaluation:	_____					

Comments:

** Attach additional sheets as necessary. **



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INCIDENT EXPOSURE RECORD

Name: _____ Department: _____

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Fire Service Casualty: ☐ Yes ☐ No SRT HazMat Team Member: ☐ Yes ☐ No

Civilian Casualty: ☐ Yes ☐ No Spiller/Employee: ☐ Yes ☐ No

Work Performed By: _____

Observations/Reactions/Comments: _____

Current Symptomology

Pre-Exposure BP: _____ Pulse: _____ Resp: _____ Pupil Resp: _____ Lungs: _____

Post-Exposure: BP: _____ Pulse: _____ Resp: _____ Pupil Resp: _____ Lungs: _____

HazMat Involved Name: _____ DOT Placard No: _____

Exposure Time: _____ In: _____ Out: _____ Total Time: _____

Prot Equip Used (Type): _____

Decon/Routine/Emerg: _____

Disposition/Transport: _____

**** This form is to be completed by the Medical Branch and must accompany exposure victim to the hospital. ****