Franklin County Fire-Trax Accountability System Fire/EMS/Municipality Form

ID# (Last Four Numbers of SS #) ________________ Date Completed ________________

Department Affiliation ____

First Name ________________________________ Last Name ________________________________

DOB __________________________________

FD/EMS Position: (circle one) FF FF/EMT FF/Paramedic FF/EMR Fire Police Jr Member EMT Paramedic Driver

Municipality: EMA Coordinator Supervisor Deputy EMA Assistant EMA Employee

Initial Hire Date (Paid or Volunteer) ____

Emergency Contact Name ____

Emergency Contact Address ____

Emergency Contact

Primary Phone # ____________________________ Secondary Phone # ____________________________

Allergies:

1. ________________________ 2. ________________________ 3. ________________________

4. ________________________ 5. ________________________ 6. ________________________

Medical History (circle any that applies)

1. Diabetic
2. Breathing problems
3. Heart related conditions
4. Hypertension

FIRE/EMS/MUNICIPAL DEPARTMENT WILL KEEP A COPY FOR THEIR RECORDS.

I HEREBY AUTHORIZE THE DEPARTMENT OF EMERGENCY SERVICES AND OTHER NECESSARY MEDICAL PERSONNEL TO VIEW MY MEDICAL INFORMATION.

SIGNED BY: DATE: