



WVPST Martinsburg Pre-Burn Accountability/Evaluation Form

Location: _____

Date: _____

Live Burn Accountability

Individual Name: _____

Department: _____

Emergency Contact: _____

Allergies: _____

Known Medical Problems: _____

Note: **Remember to keep crews well hydrated during time in staging or rehabilitation**

VITAL SIGNS	B/P	RESP.	PULSE	TEMP.	SKIN	Hydrated	TAKEN BY:
Base Line						Y / N	
Post Entry #1						Y / N	
Post Entry #2						Y / N	
Post Entry #3						Y / N	
Post Entry #4						Y / N	
Post Entry #5						Y / N	
Post Entry #6						Y / N	
Post Entry #7						Y / N	

PERSONNEL/TURNOUT GEAR INSPECTION:

Coat: _____ Pants: _____ Helmet: _____ Boots: _____

Gloves: _____ Hood: _____ SCBA: _____ Pass: _____

Accountability: _____ Problems with Personnel/Gear: _____

TRAINING LEVEL: The above named individual meets the following training Job Performance Requirements (JPR). These NFPA 1001 JPR subjects are listed in the appendix of NFPA 1403.

Safety
Personal Protective Equipment
Overhaul

Fire Behavior
Ladders
Water Supply
Forcible Entry

Portable Extinguishers
Fire Hose, Appliances, and Streams
Ventilation
Live Burn Building Orientation

I _____ certify that I have received the above training prior to entering the Live Fire Training being offered here. I also certify the above information is true.

Signature: _____
(Legible Signature)

_____/_____/_____
(Date)

Signature of Lead Instructor: _____ Date: ____/____/____

Signature of Safety Officer: _____ Date: ____/____/____



WVPST Martinsburg

Live Fire Training

Recommended Medical Parameters

The information listed below is intended for use as a guideline for the evaluation of firefighters during Baseline and Post Entry physical evaluations. The final decision on allowing a person to begin or continue training must be based on the best judgment of the on site medical personnel according to all the information available in each individual situation. Students and instructors should not be allowed to begin or continue training against medical advice. The Lead Instructor shall ensure that medical advice is followed and not override that advice.

1. **Blood Pressure – diastolic greater than 105 mm Hg or a resting blood pressure greater than 160/100 mm Hg.**
2. **Pulse – greater than 70 percent of the maximum heart rate (220 – age)**
3. **Respiratory Rate – greater than 24 per minute**
4. **Temperature – greater than 99.5 deg. F (oral) or greater than 100.5 deg. F (core) or less than 98.0 deg. F (core).**
5. **Mental Status – altered status such as slurred speech, clumsiness, or weakness.**
6. **Skin – temperature, color, injuries**

A student or instructor who does not meet these guidelines should be allowed to extend his or her stay in rehab. and then be reevaluated. If after a reasonable period, in the opinion of the EMS Officer, these guidelines cannot be met, the person should be removed from further participation for the remainder of the day and the lead instructor should be notified.

NOTHING IN THIS GUIDELINE IS TO REPLACE THE JUDGEMENT OF ON SITE MEDICAL PERSONNEL THAT WOULD INDICATE THAT A PERSON IS IN MEDICAL DISTRESS AND IN NEED OF IMMEDIATE TRANSPORT TO A MEDICAL FACILITY.

I understand that the personal health information being documented on this form is in compliance with NFPA 1582: *Standard on Comprehensive Occupational Medical Program for Fire Departments*, 2007 Edition as referenced in NFPA 1403: *Standard on Live Fire Training Evolutions*, 2007 Edition All personal information gathered on this form will be used for the sole purpose of evaluation for continued participation during Live Fire Training Evolutions.

Furthermore, I give the lead Emergency Medical Service Agency and The West Virginia licensed Emergency Medical provider the authority to use my personal information listed within this form if I become incapacitated and the need for medical transport is required for continuation of care at an approved medical facility.

I understand I have the right to revoke the authority at any time. I understand that if I revoke this authority I must do so in writing and present my written revocation to the agency. The information contained in this form will be held confidential for a period of not less than 5 years and is not to be shared with anyone other than the individuals having interest in my immediate medical condition. I understand the revocation will not apply to information that has already been released in response to this authority. This authorization will expire 30 days from the date listed below.

In accordance with The Health Insurance Portability and Accountability Act of 1996 (HIPAA) I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

Date of Live Fire Training Evolution(s) _____

Printed Name: _____

Signature: _____