WCT Medical Incident Checklist

This form is to be filled out by the WCT Administrator or Supervisor for all heart events, severe leg pain, and loss of consciousness events that occur during the WCT through 24 hours after taking a WCT. Send completed form to Dr. Jennifer Symonds, FAM Medical Officer, jmsymonds@fs.fed.us; fax 866-338-6630.

WCT – Arduous / Moderate / Light (circle)
Primary fire / Collateral / AD (circle)
ICS Qualifications___________________

Date of Incident___________________
Level of EMS monitoring WCT: (circle one)List
EMR / EMT / AEMT / Paramedic

Male ___Female ___
Age_________________
Height ______________
Weight_____________

Environmental conditions at WCT:
Temp_________________
Humidity_______________
Elevation_______________

Event occurred DURING / AFTER the WCT (circle)
Did individual eat a typical diet for them prior to the WCT? Yes / No (circle)

Brief Description of individual's PT Program for past 3 months:

____

____

____

Cardiac/Heart Event/Unconscious

Medical Treatment provided by EMS at test:

- ___ CPR
- ___ AED
- ___ Oxygen
- ___Other:__________

Known preexisting condition:

- ___ high blood pressure
- ___ heart attack
- ___ heart/artery disease
- ___ diabetes
- ___ high cholesterol
- ___ recent head trauma

Compartment Syndrome/Rhabdomyolysis

Medical Treatment provided by EMS at test:

- ___ IV fluids
- ___ Other: ______________________
- ___ History of recurrent shin splints
- ___ Recent trauma to legs (last 3 weeks)
- ___ Use of diet supplements (creatine, protein powder, etc.)
- ___ Use of energy drink/supplement in last 24 hours
- ___ Recent Illness in last 3 weeks
- ___ Taking prescribed medication: ____________________
- ___Taken OTC Medication in last 48 hours: ____________

Signs/Symptoms Present:

- ___ Chest Pain/Clutching Chest
- ___ Shortness of Breath
- ___ Nausea/Vomiting
- ___ Neck/Jaw/Arm Pain
- ___ Headache/Vision Problems

- ___Muscle Weakness
- ___Muscle Pain
- ___Dark/Red Urine

Continue on back….

WCT Medical Incident Checklist

Cardiac/Heart Event/Unconscious cont.

Medical Diagnosis from Medical Provider:

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____

Compartment Syndrome/Rhabdo cont.

Medical Diagnosis from Medical Provider:

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___ Sent home from ER

___ Admitted to hospital

Submitted by: ____

Forest/District: ____

Phone: ______________________________ Email: __________________________________

Date Submitted: _______________________