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| **NOMBRE** |  | **N° DE DOCUMENTO** |  |
| **CONTACTO** **EMERGENCIA** |  | **TELEFONO** |  |
| **COMPONENTE USAR** |  | **FECHA** |  |

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| ***Responda las siguientes preguntas*** | | | | | | | | | | | | | | | | | | | |
| 1. *¿Tiene actualmente alguna restricción laboral o por enfermedad?* ***Sí*** *\_\_\_\_\_\_* ***No*** *\_\_\_\_\_\_* 2. *¿Ha estado en incapacitado por lesión o enfermedad en los últimos 14 días?*  ***Sí*** *\_\_\_\_\_\_* ***No*** *\_\_\_\_\_\_* 3. *¿Tiene antecedentes de enfermedad crónica con o sin tratamiento?* ***Sí*** *\_\_\_\_\_\_* ***No*** *\_\_\_\_\_\_* 4. *¿Está tomando actualmente medicamentos?*   *(liste medicamento y condición de salud)* ***Sí*** *\_\_\_\_\_\_* ***No*** *\_\_\_\_\_\_*  *(Medicamento)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (condición) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *(Medicamento)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (condición) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *(Medicamento)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (condición) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*   1. *¿Tiene alguna lesión o problema osteomuscular que limite su movilidad?*  ***Sí*** *\_\_\_\_\_\_* ***No*** *\_\_\_\_\_\_* | | | | | | | | | | | | | | | | | | | |
| ***“Certifico que la información registrada es verdadera, las respuestas se contestaron con honestidad y conocimiento del riesgo al cual me podría exponer si oculto información sobre mi condición de salud.”*** | | | | | | | | | | | | | | ***Firma*** | | | | | |
| **EXAMEN FISICO** | | | | | | | | | | | | | | | | | | | |
| ***HORA*** | *\_\_\_\_:\_\_\_\_* | | | ***Pulso*** | |  | ***Respiración*** | |  | ***Presión arterial*** | | */* | ***T°*** | |  | ***SatOx2*** | |  | |
| ***HORA*** | *\_\_\_\_:\_\_\_\_* | | | ***Pulso*** | |  | ***Respiración*** | |  | ***Presión arterial*** | | */* | ***T°*** | |  | ***SatOx2*** | |  | |
| *Cabeza y cuello* | |  | | | | | | | | | | | | | | | | | |
| *Cardiopulmonar* | |  | | | | | | | | | | | | | | | | | |
| *Abdomen* | |  | | | | | | | | | | | | | | | | | |
| *Extremidades* | |  | | | | | | | | | | | | | | | | | |
| *Neurológico* | |  | | | | | | | | | | | | | | | | | |
| ***Observaciones:*** | | | | | | | | | | | ***Certificado de vacunación internacional*** | | | | | | ***Sí*** | | ***No*** |
| ***Aprobado despliegue*** | | |  | | ***No aprobado*** | | |  | ***Motivo no aprobado su despliegue*** | | | | | | | | | | |
| ***Jefe Médico:******Firma:*** | | | | | | | | | | | | | | | | | | | |
| ***Líder Equipo USAR:******Firma:*** | | | | | | | | | | | | | | | | | | | |

**Monitoreo Diario**

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| **Fecha** | **Hora** | **Fc** | **Fr** | **TA** | **O2x** | **T°** | **Síntomas** |
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**Procedimientos**

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| **Fecha** | **Hora** | **Síntomas** | **Tratamiento** | **Medicamentos** | **Realizado por** |
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