



EMS Education
HEALTH RECORD

DIRECTIONS: Have your physician or college health fill out and sign the Health Record. This must be on file with your immunization records prior to attending any EMS or Hospital clinical experience or ride along.

Name _____ Birth Date _____
Last First Middle

Home Address _____
Phone No. _____

I. MEDICAL EXAMINATION

Physician check if any abnormal history or physical findings:

- _____ Cardiovascular System Remarks _____
- _____ Respiratory Remarks _____
- _____ Gastrointestinal Remarks _____
- _____ Genitourinary-Gynecologic Remarks _____
- _____ Central Nervous System Remarks _____
- _____ Musculo-Skeletal Remarks _____
- _____ EENT(include visual & hearing acuity) Remarks _____
- _____ Scoliosis Remarks _____

List all medications student is taking. _____

Are there any health conditions which should be called to our attention (including communicable or infectious disease or latex allergies)? _____

The clinical experience for EMT students may require prolonged standing and walking; frequent heavy lifting, pushing, pulling, carrying; occasional climbing, stooping, balancing, kneeling; constant need for good vision and hearing; ability to tolerate stressful situations; and occasional exposure to hazardous material.

List any contra-indications to participation in clinical EMT experiences. _____

This is to certify that I have examined this student and find that he/she is able to participate in ANY clinical EMT experiences.

Date of examination _____ Examining Physician/NP/PA _____
Address _____

II. REQUIRED IMMUNIZATIONS MUST BE ON FILE IN COLLEGE HEALTH

Immunizations must be documented by a physician, their office personnel, college health, or a health department representative. students are not authorized to complete the form

III. TUBERCULIN SKIN TEST REQUIRED ANNUALLY.

(Over)



**BUTLER COMMUNITY
COLLEGE
EMS EDUCATION
HEALTH RECORDS**



Name: _____

Required immunizations, Tests, & or Titers (Attach a Photocopy)

1. **TDAP** in last 10 years Date: _____

2. **MMR-**
(2 shots needed at least 30 days apart) #1 Date: _____
(Cannot be given during pregnancy) #2 Date: _____
OR Measles, Mumps, and Rubella Titer Date: _____ Results: _____

3. **VARICELLA**
I had chickenpox on _____
(Date of disease) (Physician Signature)

OR Varicella Vaccine #1 Date: _____
#2 Date: _____

OR Varicella Titer Date: _____ Results: _____

4. **TB SKIN TEST**
2 Step required: Date planted: _____ Results: _____mm Date read: _____
Date planted: _____ Results: _____mm Date read: _____

5. **Seasonal Flu** (Sept. 1 –April 30)
(Not needed Summer Semester) Date: _____

6. **HEPATITIS A & B (Optional)** Date #1: _____
Date #2: _____
Date #3: _____

HEPATITIS A & B VACCINE WAIVER

The Hepatitis Vaccine is safe. You are considered to be a higher risk of contracting Hepatitis A & B because you will be working in the Pre-Hospital and Hospital setting. Approximately 15-20% of people who work in these areas are immune. If you are immune, you will of course not need immunized.

Circle appropriate response and sign:

YES I understand the risks and benefits of immunization with the Hepatitis A & B vaccine. If I am not immune, I will seek the vaccination.

Signed: _____ Date: _____

NO I understand the risks and benefits of immunization with the Hepatitis A & B vaccine. Despite potential benefits, I prefer NOT to be immunized at this time.

Signed: _____ Date: _____

Have you ever had Hepatitis?

If yes, what type?

Other Comments: