

ERIE COUNTY HEALTH DEPARTMENT, EMS DIVISION

ERIE COU	NT	Y EMS PRO)GI	RAM HEAL	TH	EXAMIN	ATIC	ON FORM	
This form must be co									
first class for the cou									
year. The form must be completed & signed by a licensed health care provider. Immunization records are to be attached prior to submitting the following form. All immunization records are to be in English.									
Name:						Sex:	DoB:	/ /	
Emergency Contac	t:			Relatio	n:		Ph #:		
Course:		Course #:		Course Loc	atior	n:			
HEALTH HISTORY									
Last Physical Exam Date:									
Height:	Wei	ght:	BP	•	Pu	ılse:	R	Resp:	
Allergies (if applic	able)	:					•	•	
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System Review &						E		G 1	
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□ Dental□ Neck		Lungs		Genitourinary		Neurological		Musculoskeletal	
Abnormalities Note				Diagnose				1v1uscu10sRcicial	
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			M	EDICATIONS	5				
Current List of Medic	cation	ıs:							

Printed Name:	
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Students cannot register for the program until they have fulfilled the required immunizations listed under the "Immunization" section of the health form. Please Submit All Dates in Mm/DD/YYYY FORMAT FOR THE FOLLOWING: MMR (combined Measles, Mumps, Rubella) Two (2) doses of MMR vaccine (given after 01/01/1968; both administered after first birthday & at least 28 days apart. OR OR	IMMUNIZATIONS							
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One lifetime adult Tdap or pediatric DTaP (contains pertussis) is required. Adult Tdap Vaccine Date		Circle: Td or Tdap or DTaP						
DTaP (contains pertussis) is required.		Adult Tdan Vaccine Date						
Diai (contains pertussis) is required.								
Must complete both fields even if the Pediatric DTaP Vaccine Date	• • • • • • • • • • • • • • • • • • • •	Pediatric DTaP Vaccine Date						
date is the same	*	AND AFFICANCIANTS TO BOOMY						
DATES REQUIRED FOR BOTH		**DATES REQUIRED FOR BOTH**						

rinted Name:							

VARICELLA	Dose #1	
Must demonstrate immunity through the following:	Dose #2	
Two doses of varicella vaccine; both		
administered after first birthday and at		OR
least 28 days apart.		
OR	Provider/Clinicia	n Diagnosis
Medical provider/clinician documented		O.D.
history of varicella (chickenpox) disease.		OR
OR	Varicella Titer Da	to
Serology (blood test): Positive varicella	**MUST ATTACH	LAB REPORT WITH REFERENCE
IgG antibody titer confirming immunity.	RANGE**	
HEPATITIS A		
	Dose #1 Dose #2	
	Dose 112	OR
	I acknowledge tl	ne risks associated with
		cline immunization at this time.
	Trepatitis 71 & uc	chile inimumzation at this time.
	Signature:	Date:
POLIO	Dose #1	
	DOSC #Z	
	D08C #3	
	Dose #4	
COVID-19	Dose #1	
All students are encouraged to remain up	Dose #2 (if neede	ed)
to date with COVID-19 vaccinations.	Additional (if nee	eded)
Health-related students are no longer	Additional (if nee	eded)
required to submit proof of COVID-19		OR
vaccination.	I acknowledge tl	ne risks associated with COVID-
Must include the manufacturer's name	19 & decline imi	nunization at this time.
on the line next to each dose or attach an		
official immunization record.	Signature:	Date:
CERTIFICATION OF IMMUNIZAT	IONS BY HEAL	TH CARE PROVIDER
Provider Signature:		Date:
5		
Provider Name (Print):		Phone:
		Fax:
Provider Street Address:		
City/Town:	State:	Zip Code:
Email:		

I IIIICG I (GIIIC)	Printed Name:							
	Printed Name:							

PHYSICAL EXAM FINDINGS

ATTENTION MEDICAL PROVIDER

The following are basic physical & mental attributes needed to be possessed within the school program for successful completion and to become certified as a NYS EMS Provider:

- Communicate effectively via telephone and radio equipment.
- Lift, carry and balance up to 125 pounds (250 pounds with assistance).
- Interpret oral, written, and diagnostic form instructions.
- Use good judgment and remain calm in high stress situations.
- Be unaffected by loud noises and flashing lights.
- Function efficiently without interruption throughout an entire work shift.
- Calculate weight and volume ratios.
- Read English language manuals and road maps/GPS.
- Accurately discern street signs and addresses.
- Interview patients, patient family members and bystanders.
- Document, in writing, all relevant information in prescribed format, in light of legal ramifications of such.
- Converse, in English, with coworkers and hospital staff with regard to the status of the patient.
- Perform all tasks related to the highest quality patient care.
- Bend, stoop, and crawl on uneven terrain.
- Withstand varied environmental conditions such as extreme heat, cold and moisture.
- Work in low light situations and confined space.
- Work with other providers to make appropriate patient care decisions.

To the best of my knowledge, this patient is free of any physical or mental impairment which is of potential risk to patients/personnel, or which might interfere with the performance of their basic job duties described above, including the habituation or addiction to depressants, stimulants, narcotics, & other drugs.

If the provider cannot certify, an explanation letter with medical provider signature must accompany this form.						
Provider Signature:	Date:					
Provider Name (Print):						

TUB	ERCULOSIS SCRI	EENING			
PART A (please select yes or no):					
Have you ever had a positive PPD	, TB QuantiFERON, o	r T-SPOT test?	□ YES	□ NO	
Student Signature:			Date:		
PART B (TO BE COMPLETED BY	MEDICAL PROVID	DER):	1		
**ATTENTION MEDICAL PROVI					
• If the student answered NO to the	above question, a PPD	TB test is REQ	UIRED.		
o PPD TB test must be com	pleted within one caler	ndar year (unless	s history of pos	sitive TB	
test – see below).					
 If PPD result is 10mm or is REQUIRED. 	more, or T-SPOT or TI	3 QuantiFERON	I is positive, a	chest x-ray	
If the student answered YES to the	e above question, a che	st x-ray is REQ	UIRED.		
 If the student has a history 				ERON),	
document date & result of					
o MUST ATTACH LAB RE		•	ON IS COMPL	ETED.	
O Chest X-ray test must be o	•				
History of BCG vaccination does	NOT exclude the stude	ent from this requ	uırement.		
PPD TB TEST	<u> </u>	Indurati	<i>I</i>		
PPD PPD Date Placed: Date					
CHEST X-RAY & BLOOD TEST	e Read:	Measur	ement (mm):		
QuantiFERON-TB Gold or	QFT-G or T-Spot	Result (Circle O	ne): Positiva	Negative	
T-Spot Collected Date:		ST ATTACH LA			
**CHEST X-RAY REQUIRED					
	GOLD/T-SPOT*				
Chest X-Ray	Chest X-	Ray			
Date:	Result:				
Does the student have any of the f			□ YES	□ NO	
sputum production > three (3) wee					
weight loss > ten (10) pounds, dre	nching night sweats, u	nexplained			
fever, fatigue > three (3) weeks?			_ AMDG	- 110	
• If negative chest x-ray and positiv	· · · · · · · · · · · · · · · · · · ·	ent complete a	□ YES	□ NO	
course of INH or other TB treatme					
 If yes, name & dose of medication Date range of treatment 					
 Date range of treatment _ Number of months of treatment _ 	tment				
Provider Signature	iment				
Provider Signature:			Date:		
Provider Name (Print):			Phone:		
, ´			Fax:		
Provider Street Address:					
City/Town:		State:	Zip Code:	<u> </u>	
Email:	·				

Printed Name: _____