ERIE COUNTY EMS PROGRAM HEALTH EXAMINATION FORM

This form must be completed in full in order to attend any Erie County EMS course. It is due at the start of the first class for the course the student is registered for. Exam date/health data must be from within the last calendar 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 Contact:	Relation:	Ph #:
Course:	Course #:	Course Location:

HEALTH HISTORY

Last Physical Exam Date:

Height:	**Weight:**	**BP:**	**Pulse:**	**Resp:**

Allergies (if applicable):

System Review & Abnormal Findings Listed Below:

☐ HEENT	☐ Lymph Nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

Abnormalities Noted/Recommendations:	Diagnoses/Problems:

MEDICATIONS

Current List of Medications:

Printed Name: _____

IMMUNIZATIONS	
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 • Serology (blood test): Positive IgG antibody titers confirming immunity to measles, mumps, & rubella.	Dose #1 _____ Dose #2 _____ OR MMR Titer Date _____ ****MUST ATTACH LAB REPORTS WITH REFERENCE RANGE****
MENINGOCOCCAL VACCINE OR WAIVER New York State requires all students to: • Receive at least one dose of Meningococcal ACWY vaccine within five (5) years of entering program. OR (see next page) • Receive two (2) doses (full series) of Meningococcal B vaccine. OR • Sign a waiver specifically declining Meningococcal immunization.	MenACWY Dose #1 _____ OR MenB Dose #1 _____ MenB Dose #2 _____ OR **I acknowledge the risks associated with meningococcal infection (meningitis) and decline immunization at this time.** Signature: Date:
HEPATITIS B • Three (3) dose series (Heplisav-B only requires two (2) doses) OR • Serology (blood test): Positive Hepatitis B surface antibody, QUANTITATIVE titer confirming immunity. OR • Sign a waiver specifically declining Hepatitis B immunization.	Dose #1 _____ Dose #2 _____ Dose #3 _____ (Indicate "N/A" in #3 if you had Hepslisav-B) OR Hepatitis B Titer Date _____ ****MUST ATTACH QUANTITATIVE LAB REPORT WITH REFERENCE RANGE**** OR **I acknowledge the risks associated with meningococcal infection (meningitis) & decline immunization at this time.** Signature: Date:
TETANUS-DIPHTHERIA • Tetanus (Td/Tdap/) booster within last ten (10) years. • One lifetime adult Tdap or pediatric DTaP (contains pertussis) is required. • Must complete both fields even if the date is the same.	Last Tetanus Booster Date _____ **Circle**: Td or Tdap or DTaP Adult Tdap Vaccine Date _____ Pediatric DTaP Vaccine Date _____ ****DATES REQUIRED FOR BOTH****

Printed Name: _____

VARICELLA Must demonstrate immunity through the following: • Two doses of varicella vaccine; both administered after first birthday and at least 28 days apart. OR • Medical provider/clinician documented history of varicella (chickenpox) disease. OR • Serology (blood test): Positive varicella IgG antibody titer confirming immunity.	Dose #1 _____ Dose #2 _____ OR Provider/Clinician Diagnosis _____ OR Varicella Titer Date _____ ****MUST ATTACH LAB REPORT WITH REFERENCE RANGE****
HEPATITIS A	Dose #1 _____ Dose #2 _____ OR **I acknowledge the risks associated with Hepatitis A & decline immunization at this time.** Signature: Date:
POLIO	Dose #1 _____ Dose #2 _____ Dose #3 _____ Dose #4 _____
COVID-19 • All students are encouraged to remain up to date with COVID-19 vaccinations. • Health-related students are no longer required to submit proof of COVID-19 vaccination. • Must include the manufacturer's name on the line next to each dose or attach an official immunization record.	Dose #1 _____ Dose #2 (if needed) _____ Additional (if needed) _____ Additional (if needed) _____ OR **I acknowledge the risks associated with COVID-19 & decline immunization at this time.** Signature: Date:

CERTIFICATION OF IMMUNIZATIONS BY HEALTH CARE PROVIDER

Provider Signature:		Date:
Provider Name (Print):		Phone: Fax:
Provider Street Address:		
City/Town:	State:	Zip Code:
Email:		

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):	

Printed Name: _____

TUBERCULOSIS SCREENING		
PART A (please select yes or no):		
• Have you ever had a positive PPD, TB QuantiFERON, or T-SPOT test?	☐ YES	☐ NO
Student Signature:	Date:	

PART B (TO BE COMPLETED BY MEDICAL PROVIDER):

****ATTENTION MEDICAL PROVIDER****
• If the student answered NO to the above question, a PPD TB test is REQUIRED.
  ○ PPD TB test must be completed within one calendar year (unless history of positive TB test – see below).
  ○ If PPD result is 10mm or more, or T-SPOT or TB QuantiFERON is positive, a chest x-ray is REQUIRED.
• If the student answered YES to the above question, a chest x-ray is REQUIRED.
  ○ If the student has a history of a positive TB test (PPD, T-SPOT, or TB QuantiFERON), document date & result of the test, as well as treatment information.
  ○ MUST ATTACH LAB REPORT IF T-SPOT OR QUANTIFERON IS COMPLETED
  ○ Chest X-ray test must be completed within one calendar year.
• History of BCG vaccination does NOT exclude the student from this requirement.

PPD TB TEST		
PPD Date Placed:	PPD Date Read:	Induration/ Measurement (mm):

CHEST X-RAY & BLOOD TEST	
QuantiFERON-TB Gold or T-Spot Collected Date:	QFT-G or T-Spot Result (Circle One): *Positive* *Negative* ****MUST ATTACH LAB REPORT****
****CHEST X-RAY REQUIRED IF: PPD ≥ 10MM OR POSITIVE QUANTIFERON-TB GOLD/T-SPOT****	
Chest X-Ray Date:	Chest X-Ray Result:

• Does the student have any of the following symptoms: cough with sputum production > three (3) weeks, bloody sputum, unintended weight loss > ten (10) pounds, drenching night sweats, unexplained fever, fatigue > three (3) weeks?	☐ YES	☐ NO

• If negative chest x-ray and positive TB test, did the student complete a course of INH or other TB treatment?
  ○ If yes, name & dose of medication _____
  ○ Date range of treatment _____
  ○ Number of months of treatment
	☐ YES	☐ NO

Provider Signature		
Provider Signature:		Date:
Provider Name (Print):		Phone: Fax:
Provider Street Address:		
City/Town:	State:	Zip Code:
Email:		