NEW RIVER
EMS Programs

**Student Health Physical**
**(All information will remain CONFIDENTIAL)**

Dear Provider:

This individual is interested in EMT or Paramedic class. Please complete the attached physical exam while keeping in mind the following question – **in your opinion, do you feel this person is physically capable of performing his/her responsibilities as a student?** Please understand that we consider pregnancy a normal state. If there is no complication in the pregnancy, no special considerations are needed.

The physical strength demands are as follows:

Heavy work: Exerting 50 to 100 pounds of force occasionally and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects.

The following items are other requirements that are essential for these positions.

- **Physical**: standing, walking, sitting, lifting, carrying, pushing, pulling, climbing stairs, in/out vehicles, operating equipment/machinery, stooping, crouching, crawling, reaching, head/neck movement.
- **Mental**: alertness, precision, ingenuity, problem solving, analytic ability, memory, creativity, concentration.
- **Interpersonal**: talking, persuasiveness, imagination, initiative, speaking ability, diplomacy, judgment, patience.
- **Coordination**: balancing, handling, controls (buttons, knobs, pedal, levers, cranks), driving, grasp, manual dexterity.
- **Perception**: feeling, seeing, hearing, tactile/auditory/olfactory discrimination, aesthetic sense, spatial aptitude.

**Immunization/Testing Information**

- **Tuberculin Skin Test (Mantoux Method)** - A TB test is required within the year before starting clinical and every year after. A student will only be allowed into a clinical area with EITHER documentation of a negative TB test or a negative chest x-ray. **A two-step TB is required if this is the first time a student has been tested or if it has been more than 1 year since the last test. A two-step simply means that the TB test is administered and then repeated again 1-3 weeks.**
- **Hepatitis B** - The 3-dose hepatitis B vaccination series (#1 now, #2 in 1 month, #3 in 5 months after #2) **OR** positive serologic testing is required.
- **MMR (Measles, Mumps, Rubella) - Measles and mumps:** 2 doses of measles and mumps vaccines at least 28 days apart **OR** Healthcare provider diagnosed history of measles and mumps disease **OR** Laboratory evidence of measles and mumps immunity is required. **Rubella:** 1 dose of rubella vaccine **OR** Laboratory evidence of rubella immunity is required. Pregnancy should be avoided for 1 month after vaccination.
- **Tetanus, Diphtheria, Pertussis** - Due to the increase in Pertussis and the subsequent risk to unprotected clients, students must have a Tdap vaccination.
- **Varicella (chickenpox)** – healthcare provider documentation of a personal history of chickenpox, having had the varicella vaccine(s), or a titer is required prior to entering the clinical area.

- **Flu vaccine** – the seasonal flu vaccine is required.
-

**IMPORTANT! MMR and varicella vaccines should be administered on the same day. If not, they must be separated by 4 weeks.**

**IMPORTANT! If the two-step TB test is needed, the MMR should be given with the 2nd TB test. If the MMR is given 1st, a student must wait 6 weeks before getting the TB test.**

**It is the student's responsibility to pay for all costs incurred in obtaining the physical exam.**

- Additional immunizations may be required by individual facilities or when the CDC recommends seasonal immunizations due to infectious diseases.

NEW RIVER
EMS Programs

**NEW RIVER COMMUNITY AND TECHNICAL COLLEGE**

**STUDENT HEALTH PHYSICAL (Form B)**

Student name _____ Date _____

Address _____

Gender (circle) M F Date of birth _____ Social security # _____

Technology: (circle) EMT Paramedic

**HEALTH HISTORY (student must complete prior to physical exam):**

| **Explain "YES" responses following the question** | **YES** | **NO** |
|---|---|---|
| 1. Have you had a medical illness or injury since your last checkup? | | |
| 2. Have you ever been hospitalized overnight? | | |
| 3. Have you ever had surgery? | | |
| 4. Are you currently taking any prescription or nonprescription (over-the-counter) medications, herbs, or supplements? If yes, list all medications. | | |
| 5. Do you have any allergies, including allergy to latex? Any food allergies to bananas, avocados, potatoes, tomatoes, kiwis, chestnuts, peaches, papaya? | | |
| 6. Have you ever been considered disabled? | | |
| 7. Do you require any special adaptive equipment? | | |
| 8. Do you think you are in good health? If no, explain. | | |

| Have you had any of the following? | YES | NO | Have you had any of the following? | YES | NO |
|---|---|---|---|---|---|
| Diabetes | | | Any immune system disease | | |
| Eye disease | | | Asthma | | |
| Ear or hearing problems | | | Tuberculosis | | |
| Heart disease | | | Hepatitis | | |
| High blood pressure | | | Measles | | |
| Hernia or rupture | | | Mumps | | |
| Back/extremity problems | | | Rubella | | |
| Fainting or blackout spells | | | Chickenpox | | |
| Epilepsy or convulsions | | | Psychiatric disorder | | |

Explain any "YES" responses here

_____

_____

_____

I certify that all statements made by me on this medical history are true and complete to the best of my knowledge.

Signature _____ Date _____

**Physical examination** Student name _____

| Height | Weight | Blood pressure | Heart rate |
|---|---|---|---|
| | | | |

Wears glasses/Contacts/Neither (circle) Hearing: right _____ left _____

| **Vision** | **Uncorrected** | **Corrected** |
|---|---|---|
| Right | 20/ | 20/ |
| Left | 20/ | 20/ |
| Both | 20/ | 20/ |

Color vision (ISHIHARA 14 Color Plate or equivalent)

Normal _____ Deficient _____

| **Findings** | **Normal** | **Abnormal (indicate nature and degree)** |
|---|---|---|
| Skin/scalp | | |
| Eyes | | |
| Ears | | |
| Nose | | |
| Mouth and teeth | | |
| Pharynx | | |
| Head/neck | | |
| Lymph nodes | | |
| Thyroid | | |
| Chest | | |
| Breasts (optional) | | |

| | | |
|---|---|---|
| Lungs | | |
| Heart | | Rhythm Murmur |
| Abdomen | | |
| Hernia | | |
| Back/spine | | |
| Musculoskeletal | | |
| Neurologic | | |
| Psychiatric | | |

Any diagnostics ordered? (i.e. EKG, UA, blood work) no _____ yes _____ (if yes, indicate type and attach results to physical form)

COMMENTS:

_____

_____

I certify that I have on this date examined this individual. On the basis of this examination and the medical history furnished to me, this person has no medical problems that would interfere with participation in their educational program. Agree _____ Disagree _____

Provider's signature _____ M.D. D.O. N.P. P.A. Date _____

Provider's name (print or tamp)_____

Phone _____

Address

_____

**Immunizations/testing**

| | | | |
|---|---|---|---|
| TB test - *2 step must be performed.* TB within past year would count for 1st step. Chest x-ray required if positive | #1 test placed_____<br>Result _____<br>Read _____ | #2 test placed_____<br>Result _____<br>Read _____ | |
| MMR (measles, mumps & rubella) - *2 vaccines required or titer or history* | Measles #1 dose _____<br>Mumps #1 dose _____<br>Rubella #1 dose _____ | Measles #2 dose _____<br>Mumps #2 dose _____<br>Rubella #2 dose _____ | Titer results or document history |
| Hepatitis B vaccine | #1 dose _____ | #2 dose _____ | #3 dose _____ |
| Varicella (chickenpox) - *vaccines or titer or history* | #1 dose _____ | #2 dose _____ | Titer results or document history |
| Tdap (Tetanus/Diphtheria/ Pertussis) - *Adult booster within past 10 years* | | Date _____ | |
| Flu shot | Date _____ | | |

**(To be completed by student's Physician, Nurse Practitioner, or Physician's Assistant)**

Student's Name: _____ Date of Birth: _____

**Medical History**

Does student currently or in the past had any of the following:

| **Condition** | **Yes** | **No** | **If yes, please explain** |
|---|---|---|---|
| Seizures or neurological disorder(s) | | | |
| Eye, ear, nose or throat disorder(s) | | | |
| Diabetes, thyroid or other endocrine disorder(s) | | | |
| Muscle, bone or joint disorder(s) | | | |
| Asthma or respiratory disorders(s) | | | |
| Heart or circulation disorder(s) | | | |
| Skin disorder | | | |
| Gastrointestinal disorder(s) | | | |
| Genito Urinary disorder(s) | | | |
| Psychiatric disorder(s) | | | |
| Hematological disorder(s) | | | |

**Previous Hospitalizations or Surgical History (date and reason):**

_____

**Current Medications:** _____

**Is student currently pregnant?** □ **Yes** □ **No**

**Allergies:** _____

**Physical Examination:** This is a physical evaluation for occupational ability and is not to be interpreted as a diagnostic medical examination.

| | | | |
|---|---|---|---|
| Height: | Weight: | B/P: | Pulse: |
| Ears, nose, & throat: | | | |
| Neck: | | Lymph Nodes: | |
| Skin: | | | |
| Heart: | | | |
| Abdomen: | | | |
| Extremities: | | | |
| Neurological, Auditory, Visual: | | | |

**Immunizations Record**

| **Immunization** | **Immunization Date or Lab Test Date** | **Please Attach Documentation** |
|---|---|---|
| **MMR** (measles, mumps, rubella) | 1. _____ | A._____ Record of immunization |
| **OR** | 2. _____ | **OR** |
| | | A. _____ Record of immunization |
| Measles (rubeola) | 1. _____ | B. _____ Positive antibody titer |
| | 2. _____ | |
| | | A. _____ Record of immunization |
| Mumps | 1._____ | B. _____ Positive antibody titer |
| Rubella | 1._____ | A. _____ Record of immunization |
| | | B. _____ Positive antibody titer |
| **Varicella** (chicken pox) | 1. _____ | A. _____ Record of immunization |
| | 2. _____ | B. _____ Positive antibody titer |
| **Hepatitis B** | 1. _____ | A. _____ Completed series |
| | 2. _____ | B. _____ In progress series |
| | 3. _____ | C. _____ Positive antibody titer |
| **Tetanus-Diphtheria-Pertussis** (Tdap) | 1._____ | A. _____ Record of immunization |
| **Tuberculin Tests:** | 1. _____ | A. _____ Record of negative ppd, step 1 |
| **2-Step, Blood Draw, Or Chest X-Ray** | 2. _____ | _____ Record of negative ppd, step 2 |
| Negative test required or a Clear Negative Chest X-ray | 3. _____ | B. _____ Record of negative ppd by blood draw |
| | | C. _____ Negative Chest X-ray |

**Seasonal Influenza Vaccine** 1._____ A. _____ Record of immunization

Physician, Nurse Practitioner, or Physician's Assistant
Signature:_____Date_____
Name typed or printed:
_____
_____

Address: _____Phone Number:
_____