College of the Mainland

Fire Academy/EMS Physical Form

College of the Mainland Fire Academy and EMS programs requires a physical examination by a licensed physician/health care provider to ensure the student's ability to safely complete the programs.

STUDENT: Complete following *prior* to visiting the doctor. **Please PRINT clearly.**

Name:_____Birth Date: _____/_____/_____
Last First Middle

In case of emergency, please notify: _____
Last First (Relationship) (Phone number)

Please check if you have had any of the following:

Yes	No		Yes	No	
☐	☐	Lung disease	☐	☐	Diabetes
☐	☐	Persistant cough	☐	☐	Fear of closed spaces
☐	☐	Heart trouble	☐	☐	Panic attacks/Anxiety
☐	☐	Shortness of breath	☐	☐	Vision problems
☐	☐	Pneumonia	☐	☐	Glasses/contacts
☐	☐	Abnormal chest X-Ray	☐	☐	Heat exhaustion/ heat stroke
☐	☐	Recent cold, flu, bronchitis	☐	☐	Hearing loss
☐	☐	Have you ever smoked?	☐	☐	Hearing aid
☐	☐	Do you currently smoke?	☐	☐	Take any medications
☐	☐	Fainting or seizures	☐	☐	Joint problems
☐	☐	Neurological problems	☐	☐	Heat-related issues
☐	☐	High blood pressure	☐	☐	Any other condition which may impact program performance
☐	☐	Surgery of any type			

Please explain any "Yes" answers: _____

_____

_____

Do you have any Allergies (food, medication, environmental)? Please describe reaction. Do you carry an EpiPen?

_____

_____

I hereby attest that the medical information supplied includes all medical conditions that would affect my participation in the EMS or Fire Academy. I authorize the release of current medical information on my medical history or current condition to clinical affiliates. In case of emergency, I authorize release of same information to relevant medical professionals.

If false information is given, or if significant medical information is withheld, I understand I ***will be dismissed from the program.***

Student Signature _____ Date: _____

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Medical Provider: Please evaluate the student's ability to meet the following standards:

Yes	No	N/A	
☐	☐		**Sufficient Eyesight:** observe patients, read records, manipulate equipment. Function in dim light, drive in hazy conditions. Wear protective eyewear.
☐	☐		**Sufficient Hearing:** to hear blood pressures and function in high-noise environments.
☐	☐		**Sufficient speaking, reading, writing skills**: to effectively and promptly communicate in English.
☐	☐		**Sufficient gross and fine motor coordination:** to manipulate equipment, stoop, bend, crawl, reach, twist, balance, grapple, and lift under emergency conditions.
☐	☐		**Satisfactory physical strength and endurance:** to move immobile patients, lift/carry/ balance 125 lbs while walking, stand in place for long periods of time, complete clinical rotation of 12 to 24 hours. Tolerate environmental extremes (heat/cold/wet/poor ventilation/ noise/vibrations).
*☐	☐	☐	***FIRE ACADEMY candidates only** *(mark N/A if student does not plan to attend Fire Academy--now or within the year)**:* Perform **strenuous physical activities** (e.g. lifting, pulling, climbing, crawling, crouching, reaching, and bending while operating tools and equipment up to 50 lbs. and removing victims weighting up to 200 lbs.) while wearing approximately 65 lbs. of protective clothing in extremely high temperatures in live smoke-filled environments.
☐	☐		**Satisfactory psychological function:** ensure safety (self, patient, partners), function in confined space, work at height, maintain self-control in emotionally charged situations.

Remarks/Abnormal Findings: _____

_____

_____

_____

*After careful physical examination, it is my opinion that this student has no current or past medical issues which will prevent him/her from **safely completing** indicated program(s).*

Please indicate:

☐ **EMS Program**

☐ **Fire Academy** *(see special section, above)*

Signature: _____ Date:_____

Print Name:_____

☐ Physician (MD/DO)

☐ Physician Assistant

☐ Nurse Practitioner

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Student: If you will be attending an EMT-B class (now or any time in the future), all of the immunizations listed below are required**.** If you have your immunization records (childhood, military, etc.) you may supply those or your medical provider may verify them with signatures below. **This form is meant to assist you and your medical provider determine which immunizations/tests you will require. When signed by a physician or nurse, it serves as proof of immunizations.**

Medical Professional: Please use the space below to verify past or present inoculations/ history of illness. If you administer inoculations, titers, or other medical tests as indicated, please supply the information here.

Patient Name: _____ DOB: _____

Printed Provider Name & Licensure Level: _____

REQUIRED For Clinical Rotations (EMT-B, EMT-I, and EMT-P

		Date Administered (or Date of Disease)	If Titer, Results	Initials (Medical Professional)
MMR	Inoculation 1			
	Inoculation 2			
	OR Titer			
Varicella (Chicken Pox)	Inoculation			
	OR History of dz/Titer			
TdaP	Tetanus/ Diptheria/ Pertussis Booster within 10 yrs			
Hep B	Inoculation 1			
	Inoculation 2			
	Inoculation 3			
	OR Titer			
Meningitis	Inoculation			
	OR N/A (see college regs)			
TB Test	Skin Test			
	OR Chest X-Ray			
Flu Vaccine	During Flu Season Only			
Hepatitis C	Antibody Titer			

STUDENTS: Be sure to keep a copy of this form for your personal records. COM will not provide you a copy in the future.