



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 | |
|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Lung disease | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough | <input type="checkbox"/> | <input type="checkbox"/> | Fear of closed spaces |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart trouble | <input type="checkbox"/> | <input type="checkbox"/> | Panic attacks/Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | Vision problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | Glasses/contacts |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal chest X-Ray | <input type="checkbox"/> | <input type="checkbox"/> | Heat exhaustion/ heat stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent cold, flu, bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever smoked? | <input type="checkbox"/> | <input type="checkbox"/> | Hearing aid |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you currently smoke? | <input type="checkbox"/> | <input type="checkbox"/> | Take any medications |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting or seizures | <input type="checkbox"/> | <input type="checkbox"/> | Joint problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological problems | <input type="checkbox"/> | <input type="checkbox"/> | Heat-related issues |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | Any other condition which may impact program performance |
| <input type="checkbox"/> | <input type="checkbox"/> | 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	
<input type="checkbox"/>	<input type="checkbox"/>		Sufficient Eyesight: observe patients, read records, manipulate equipment. Function in dim light, drive in hazy conditions. Wear protective eyewear.
<input type="checkbox"/>	<input type="checkbox"/>		Sufficient Hearing: to hear blood pressures and function in high-noise environments.
<input type="checkbox"/>	<input type="checkbox"/>		Sufficient speaking, reading, writing skills: to effectively and promptly communicate in English.
<input type="checkbox"/>	<input type="checkbox"/>		Sufficient gross and fine motor coordination: to manipulate equipment, stoop, bend, crawl, reach, twist, balance, grapple, and lift under emergency conditions.
<input type="checkbox"/>	<input type="checkbox"/>		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).
* <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*FIRE ACADEMY candidates only (<i>mark N/A if student does not plan to attend Fire Academy--now or within the year</i>): 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.
<input type="checkbox"/>	<input type="checkbox"/>		Satisfactory Psychological Function: ensure safety (self, patient, partners), function in confined space, work at height, and 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 providers 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.

Printed Provider Name & Licensure Level: _____

		Date Administered (Or Date of Disease)	If Titer Results	Initials (Medical Professional)
Polio	Inoculation 1			
	Inoculation 2			
	Inoculation 3			
	OR Titer			
Measles (Rubella)	Inoculation 1			
	Inoculation 2			
	OR Titer			
Mumps	Inoculation 1			
	Inoculation 2			
	OR Titer			
Rubella	Inoculation 1			
	Inoculation 2			
	OR Titer			
Varicella (Chicken Pox)	Inoculation			
	OR History of dz			
Tdap	Tetanus/ Diphtheria/ Pertussis Booster within 10 yrs.			
Hep B	Inoculation 1			
	Inoculation 2			
	Inoculation 3			
	OR Titer			
Meningitis	Inoculation			
	OR N/A (See College regulations)			
TB Test	Skin Test			
	OR Chest X-Ray			
Flu Vaccine	During Flu Season Only			