



STUDENT HEALTH HISTORY

TRAINING DIVISION

INSTRUCTIONS: The following form is to be completed by the applicant and reviewed by the physician completing your physical examination which will be scheduled by the EMS Training Division.

SECTION A – Personal Data

Name _____ D.O.B: _____ Age: _____

Phone: _____ Cell: _____ Email: _____

Address _____

City, State, Zip _____

Social Security # _____ -- _____ -- _____ Driver's License #: _____ Exp. _____

Married: Yes () No () Spouse's Name: _____

Primary Physician: _____ Phone: _____

Health Insurance Provider: _____

Policy/Member #: _____ Group #: _____

Emergency Contact #1: _____ Relation: _____

Hm. Phone #: _____ Daytime Phone #: _____

Emergency Contact #2: _____ Relation: _____

Hm. Phone #: _____ Daytime Phone #: _____

SECTION B – Health History

1. Is there any family history of the following (especially in either parent or sibling)?

Cancer ()	Diabetes ()	Tuberculosis ()
Lung problems ()	Heart problems ()	High Blood Pressure ()

2. Have you ever had any of the following?

Chicken Pox	Yes () No ()	Measles	Yes () No ()
Shingles	Yes () No ()	Hepatitis	Yes () No ()
Cancer	Yes () No ()	HIV/AIDS	Yes () No ()
Tuberculosis	Yes () No ()	Positive TB Test	Yes () No ()

3. Have you ever been hospitalized? Yes () No (). If yes, describe the nature of the illness/injury:

4. Do you require any special accommodations in the classroom setting? Yes () No ()
If yes, please explain:

5. List all allergies: _____

6. When was your last eye exam: _____

Do you wear glasses or contacts? Yes () No ()

Are you color blind? Yes () No ()

7. When was your last dental exam? What procedures were performed?

8. List all medications taken regularly: _____

Do you have or have you had been treated for the following: If “yes”, explain to the right of your answer.

- Explain:
- 9. Dizziness, fainting spells, epilepsy, severe headaches, stroke or any disease or disorder of the brain or nervous system? Head injury? Yes () No ()
 - 10. Respiratory problems such as asthma, blood tinged sputum, prolonged cough? Yes () No ()
 - 11. High blood pressure, chest pain, shortness of breath, heart trouble, swelling of legs or ankles, or rheumatic fever? Yes () No ()
 - 12. Stomach ulcer or disorders of the stomach, intestines or rectum? Yes () No ()
 - 13. Jaundice, liver condition, hepatitis? Yes () No ()
 - 14. Nephritis or any disease of the kidneys, bladder, prostate or reproductive organs? Yes () No ()
 - 15. Diabetes or sugar, albumin or blood in the urine? Yes () No ()
 - 16. Arthritis, rheumatism, gout or disease of bones, joints, or muscles, fractured or broken bones? Yes () No ()
 - 17. Cancer or tumor of any kind? Yes () No ()
 - 18. Varicose veins, varicose ulcers, phlebitis or foot problems such as bunions? Yes () No ()
 - 19. Rashes, skin conditions, hives or other Allergies? Yes () No ()
 - 20. Hernia or rupture? Yes () No ()
 - 21. Curvature of the spine, sciatica, pain down the back of the legs, back pains, back injury, back surgery, poor circulation in the legs confirmed by a physician, numbness in the feet, pain in the hips and/or knees, pain in the neck, pain in the arms or hands, repeated episodes of “pulled muscles” in the back? Yes () No ()

22. Can you assist with lifting of patients? Yes () No () Explain:
23. Can you walk or stand for extensive periods of time? Yes () No ()
24. Have you ever been treated for emotional illness, alcoholism, or drug addiction? Yes () No ()
25. Are you receiving treatment or taking medication of any kind? (Including birth control pills) Yes () No ()
26. Have you ever taken tranquilizers, anti-depressants, cortisone, anti-coagulants, heart or blood pressure medication? Yes () No ()
27. Are you allergic to any medications or have you had reactions to any drugs or medicines? (for example: Penicillin, codeine, etc.) Yes () No ()
28. Are you able to verbally communicate and interact with others? Yes () No ()
29. Do you have use of the senses of vision, hearing, touch and smell to observe, assess and evaluate situations that may occur in the classroom or clinical setting? Yes () No ()
30. Have you ever had loss of vision in either eye, glaucoma (pressure in eyeball), cataracts, double vision, serious eye injury, eye surgery? Yes () No ()
31. Do you have difficulty hearing? Have you ever had a hearing aid, ear operation, ruptured eardrum, constant discharge (drainage) from your ears? Yes () No ()
32. Have you had any previous injuries that resulted in broken bones, internal injuries? Yes () No ()
33. Have you had a medical check-up within the last two years by a physician? Yes () No ()
34. Have you ever received blood or blood products? Date _____ Yes () No ()

Explain:

35. Have you ever had a needle and mucous membrane exposure in the past? If yes, when? _____ Yes () No ()
36. Have you ever received Immune Serum Globulins or Hepatitis B Immune Globulins (HBIG)?
Date Received _____ Yes () No ()
37. Have you ever been treated for any immunological disorders? Yes () No ()
38. Do you have any medical condition not covered in this questionnaire? Yes () No ()

I hereby certify to the best of my knowledge, these answers are complete and accurate.

Signature

Date

History reviewed by:

Date

Department of Emergency Medical Services
Medical Certificate of Fitness
(Must be completed by a Physician)

EXAMINING PHYSICIAN PLEASE NOTE: It is essential that the applicant be physically and psychologically fit to perform the duties of an Emergency Medical Technician (pre-hospital care provider). See "Functional Job Analysis."

Applicants First Name:	Last	M.I.	Date of Birth:
<p>1. Does the applicant have any DISEASE CONDITIONS that would affect his/her abilities to function as an Emergency Medical Technician? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain:</p> <p>2. Does the applicant have any PSYCHOLOGICAL and/or EMOTIONAL ILLNESS that would affect his/her abilities to function as an Emergency Medical Technician? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain:</p> <p>3. Does the applicant have any MEDICAL CONDITIONS that would affect his/her abilities to function as an Emergency Medical Technician? <input type="checkbox"/> No <input type="checkbox"/> Yes, please explain:</p> <p>4. Does the applicant have the PHYSICAL ABILITY (e.g. assessing, lifting, and transferring patients) to function as an Emergency Medical Technician? <input type="checkbox"/> Yes <input type="checkbox"/> No, please explain:</p> <p>5. Does the candidate have any CONDITIONS OR LIMITATIONS that will prevent him/her from participating in the physical fitness component of the EMS Academy (daily running, weight lifting, calisthenics, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No, please explain:</p> <p>6. In summary, in your PROFESSIONAL OPINION, do you have confidence in this candidate's PHYSICAL and/or PSYCHOLOGICAL FITNESS to render emergency pre-hospital care to patients? <input type="checkbox"/> Yes <input type="checkbox"/> No, please explain:</p>			
Physician's name (<i>please print</i>)		Physician's signature	Date
			Phone
Address		Clinic or physician's stamp	
Candidate's Statement: I have answered all questions from the above noted physician honestly and truthfully.			
Candidate's Signature			Date



EMS TRAINING DIVISION

EMS Cadet Statement of Continued Health Responsibility

If there is a change in my health status, I understand a subsequent health examination the may be required by the EMS Training Division. I understand it is my responsibility throughout the program to keep immunizations, MMR, TD, and TB testing current. I agree to inform the EMS Training Division of any health problem that could possibly affect my performance or the welfare of my patients during the paramedic program. This includes exposure to varicella, measles, mumps or rubella. I understand that this disclosure is necessary to protect my health and well-being as well as the patients for whom I may provide care.

I understand that it is a requirement that I have Health Insurance coverage to enter the EMS Paramedic Academy. Also, I understand that I must maintain Health Insurance coverage throughout my enrollment in the EMS Paramedic Academy and that failure to do so is grounds for dismissal from the EMS Paramedic Academy.

I have read the above foregoing and understand my responsibility to advise the EMS Training Division Staff of any changes in my health status and/or Health Insurance coverage. I have had the opportunity to ask questions and they have been fully answered.

Signature of Student

Printed Name

Date



Proof of Immunization Compliance

STUDENT MUST COMPLETE	NAME: _____		
	Please Print	(Last)	(First) (M.I.)
	SS/ID Number: _____	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of Birth: Month _____ Day _____ Year _____			

PHYSICIAN COMPLETES	MUST BE COMPLETED BY PHYSICIAN OR HEALTH CARE PROVIDER			
	Measles (Rubeola), after 1968	Rubella	Mumps	Tetanus-Diphtheria
	1 st Immunization: _____ and (Date)	Immunization: _____ or (Date)	Immunization: _____ or (Date)	Immunization: _____ (Date within 10 years)
	2 nd Immunization: _____ or (Date)	Date of Disease: _____ or (Date)	Serologic Test: _____ (Date)	
	Date of Disease: _____ or (Date)	Serologic Test: _____ (Date)	_____ (Result)	
	Hepatitis B Vaccine	Tuberculosis Test		
	First Dose: _____ (Date)	PPD (Mantoux) within the past 12 months (tine or monovac not acceptable) Date given: _____ Date read: _____ Result: Neg <input type="checkbox"/> Pos <input type="checkbox"/> mm induration (horizontal diameter) _____ *If PPD is positive, chest X-ray result: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Date _____		
	Second dose: _____ (Date)			
	Third Dose: _____ (Date)			
	If titer performed _____ (Date)			
	Result _____			
_____ <i>(Signature of physician or other health care provider)</i> Date: _____ <i>(please address or stamp above)</i>				

**RETURN THIS FORM TO: EMERGENCY MEDICAL SERVICES
704 MAYFLOWER ST.
BATON ROUGE, LA 70821**

REMEMBER: YOU WILL NOT BE PERMITTED TO REGISTER UNTIL ALL SHOT RECORDS ARE IN COMPLIANCE OR AN EXEMPTION IS SIGNED.