PROGRAM: EMT EMC 410 FRI

REPORT OF MEDICAL EXAMINATION

TO BE COMPLETED BY THE STUDENT

Name_____ **Social security or G#:**
Gender: _____ **M** _____ **F** **Birth date:** _____ / _____ / _____
Address: _____
City: _____ **Zip:** _____ **Phone: ( ) _____ - _____**

TO BE COMPLETED BY THE EXAMINING HEALTH CARE PROVIDER

Name of Examinee: _____ DOB: _____/_____/_____

HT: _____ WT: _____ Temp: _____ Pulse: _____ BP: _____

Heart: _____ Lungs: _____ Resp: _____

Hearing – R: _____ L: _____ Eyes – R: _____ L: _____ Corrected Vision: _____

Mouth: _____ Teeth: _____ Glands: _____ Skin: _____

Spine: _____ Abdomen: _____ Inguinal Rings: _____

Neuro/muscular: _____ Extremities: _____

Allergies: _____

Medications: _____

He/She appears capable to perform the physical activities of the Vocational Program:

Yes □ ***No*** □

***Lifting and moving equipment (up to 40 lbs) and "patients" (classmates and /or mannequins)**
***Performing CPR; including performing CPR while squatting or on knees**
*** Any intervention, treatment, procedure involving standing, bending and kneeling for extended periods of time.**

Remarks:_____
_____

Examiner's name, Please print: _____

Examiner's Signature and Date_____ ***License Number:*** _____

Address: _____

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IMMUNIZATION DOCUMENTATION

Name: _____ **DOB:** _____ / _____ / _____

PROOF OF FREEDOM OF TUBERCULOSIS:

PPD skin test, QUANTEFERON blood test, or chest x-ray are acceptable forms of proof of freedom from tuberculosis.

- PPD test (date): _____ Results (date):_____ ☐ Negative ___mm. ☐ Positive___mm
  If positive, a chest x-ray (date): _____ Results: _____
- QUANTEFERON (date): _____ Results:_____
  If positive, a chest x-ray (date): _____ Results: _____

Examiner's name, Please print: _____

*Examiner's Signature and Date*_____ *License Number:* _____

FLU Vaccine for current flu season

- Date: _____ Lot#: _____ Expiration date: _____

PROOF OF IMMUNITY:
*Document date immunizations were given **OR** proof of positive titers*

Varicella: 1 _____, 2_____
- Positive Titer (numerical value):_____ Date: _____

Measles, Mumps, and Rubella (MMR): 1_____, 2_____
- Measles Positive Titer Date: _____
- Mumps Positive Titer Date: _____
- Rubella Positive Titer Date: _____

TDAP: (booster given every 10 years): Date: _____ Lot#: _____ Expiration date: _____

Hep B series: 1. Date: _____ 2. Date: _____ 3. Date: _____

Covid-19: Manufacturer: _____ 1. Date: _____ 2. Date: _____

Examiner's name, Please print: _____ ***License Number:*** _____

Examiner's Signature: _____ ***Date:*** _____

Address:_____

Documentation must be attached

I give permission to release immunization records to affiliating clinical facilities.