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
☐	☐	Persistent 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 mayimpact program performance.
☐	☐	Surgery of any type			

Please explain any "Yes" answers:

_____

Do you have any Allergies (food, medication, environmental)? Please describe your 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: _____

Updated 10FEB23.

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 communicate in English effectively and promptly.
☐			**Sufficient gross and fine motor coordination:** to manipulate equipment, stoop, bend, crawl, reach, twist, balance, grapple, bend 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 rotationof 12 to 24 hours. Tolerate environmental extremes (heat/cold/wet/poor ventilation/noise/ vibrations).
☐			**Satisfactory psychological function:** ensure safety (self, patient, partners), function in confined space, work at height, maintain self-control in emotionally charged situations.
☐			**Can this student medically tolerate various types of respirators?** Examples include simple N95 to avoid infectious exposure and various hazmat/firefighting masks. Examples of these include air-purifying respirators, supplied-air respirators, and self-contained breathing apparatus.
*☐	☐	☐	***FIRE ACADEMY candidates only** *(mark N/A if student does not plan to attend Fire Academy--now or within the year)**: perform while wearing protective clothing/gear, approximately 65 lbs., climb stairs with equipment weighing approximately 50 lbs., lift and climb/descend ladders (with victims up to 200 lbs.).*

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

Student: If you will be attending an EMT-B class (now or any time in the future), all 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 in determining 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/ Diphtheria/ Pertussis Boosterwithin 10 years			
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/ Hep C			

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