Moreno Valley College

EMS Program Student Health Record

*This program requires verification of your health and immunization status by your healthcare provider prior to the beginning of the clinical portion of the program. Submit **completed form with attached copies of titers and immunization records** to Bob Fontaine at Ben Clark training Center (16888 Bundy Ave., Riverside, CA 92518). **Make copies of all documents for your own records before submitting**. For questions please feel free to contact us at (951) 571-6393.*

Student Name:_____ **Student ID #:**_____

Address:_____

(Street) **(City)** **(Zip)**

Phone:_____

Health History

*Student Health Record is to be completed by student **prior** to giving it to the healthcare provider.*

Recent History	**Yes**	**No**	**Date of Onset**	**Describe**
Fever				
Chills				
Weight Loss				
Loss of Energy/Fatigue				
Eyes/Ears	**Yes**	**No**	**Date of Onset**	**Describe**
Poor Vision				
Color Blindness				
Double Vision				
Injury to Eye				
Cataract				
Glaucoma				
Wear Glasses/Contacts				
Ear Infection				
Mastoid Surgery				
Loss of Hearing				
Ringing in Ears				
Hearing Aid				
Nose	**Yes**	**No**	**Date of Onset**	**Describe**
Allergies				
Sinus Trouble				
Hay Fever				
Frequent Colds				
Frequent Nosebleeds				
Throat/Mouth	**Yes**	**No**	**Date of Onset**	**Describe**
Sore Throat				
Frequent Hoarseness				
Dental Problems				

Student Name:_____ **Student ID #:**_____

Lungs	**Yes**	**No**	**Date of Onset**	**Describe**
Tuberculosis				
Chest Surgery				
Asthma				
Lung Collapse				
Breast Surgery				
Pneumonia				
Shortness of Breath				
Chronic Cough				
Night Cough				
Chest Pain				
Wheezing				
Emphysema				
Heart	**Yes**	**No**	**Date of Onset**	**Describe**
Heart Surgery				
High Blood Pressure				
Heart Murmur				
Enlarged Heart				
Heart Disease/Failure				
Rheumatic Fever				
Heart Palpitations				
Heart Attack				
Heart Medication				
Circulation	**Yes**	**No**	**Date of Onset**	**Describe**
Varicose Veins				
Stroke				
Leg Ulcers				
Swelling of Ankles				
Leg Pain with Walking				
Blood	**Yes**	**No**	**Date of Onset**	**Describe**
Anemia				
Leukemia				
Other Blood Diseases				
Endocrine	**Yes**	**No**	**Date of Onset**	**Describe**
Diabetes				
Pituitary Problems				
Thyroid Problems				
Cancer or Tumors				
Head	**Yes**	**No**	**Date of Onset**	**Describe**
Headaches				
Head Injury				
Neck Injury				
Musculoskeletal	**Yes**	**No**	**Date of Onset**	**Describe**
Birth Defects				
Frequent Backaches				
Back Surgery				

Student Name:_____ **Student ID#:**_____

Disc Disease				
Back Injury or Strain				
Back X-Rays				
Chiropractic Treatment				
Arthritis				
Rheumatism				
Swollen Joints				
Amputation				
Broken Bones				
Dislocations				
Painful Feet				
Rheumatoid Arthritis				
Physical Limitations				
Lifting Restrictions				
Carpal Tunnel				
Arm or Elbow Injury				
Shoulder Injury				
Wrist or Hand Injury				
Gastrointestinal	**Yes**	**No**	**Date of Onset**	**Describe**
Ulcers				
Colitis				
Diarrhea				
Stomach Problems				
Vomiting				
Blood in Stool				
Hepatitis				
Cirrhosis				
Yellow Jaundice				
Gallbladder Problems				
Gall Stones				
Nervous System	**Yes**	**No**	**Date of Onset**	**Describe**
Epilepsy/Seizures				
Fainting Spells				
Loss of Consciousness				
Dizziness or Vertigo				
Frequent Exhaustion				
Nerve Problems				
Depression/Anxiety				
Skin	**Yes**	**No**	**Date of Onset**	**Describe**
Skin Allergies				
Skin Problems				
Eczema				
Acne				
Reaction to Chemicals				
Reaction to Medicines				

Student Name:_____ **Student ID #:**_____

Hospitalizations & Operations (*Example: Appendectomy— 1992*)

Conditions Requiring Hospitalization or Surgery	Date or Year
1.	
2.	
3.	
4.	
5.	

I certify that I have provided accurate and complete information regarding my health.

Student Signature:_____ **Date:**_____

Physical Examination

To Be Completed by Health Care Provider

Height	Weight	Blood Pressure	Pulse	O2 Level	Respiration	Temperature

Codes: **Normal** ☑; **Abnormal** ⊕; **Not Examined** N/A

Clinical Evaluation	Code	Description
Skin		
Lymphatics		
Head & Neck		
Eyes		
Vision		Visual Acuity L. Eye: Visual Acuity R. Eye:
Ears		
Hearing		Hearing Test Results:
Nose		
Mouth & Oral Cavity		
Chest & Lungs		
Extremities		
Abdomen		
Hernia		
Musculoskeletal		
Back & Spine		
Neurological		

Comments concerning above findings:_____

_____

_____

Student Name:_____ **Student ID #:**_____

Evaluation & Recommendations

Based on the information provided by the patient concerning his/her past medical history, current physical findings, and the physical tasks and demands required of the EMT program, I find this individual:

_____ ***Capable*** of preforming the required tasks

_____ ***Not capable*** of performing the required tasks

Recommendations concerning health, if indicated (*Must not hinder EMT performance before implemented*):

_____
_____
_____
_____
_____

I, (***provider signature***):_____, hereby certify that this student is cleared as of (***date***):_____ and is capable of preforming routine healthcare functions in the clinical setting. This student does not have any health conditions that will create hazards to himself/herself, fellow students, facility employees, or patients and bystanders.

CLINIC STAMP
Print Provider Name:_____ **Address & Phone:**

Student Name:_____ **Student ID#:**_____

Immunizations & Titers	Results	Vaccines	Signature & Clinic Stamp
MMR Titer **TITER REQUIRED**	**Titer Date:**_____ **Immune** Yes:_____ No:_____ ***(If "No" vaccine is needed)***	MMR Vaccine (***If titer is not immune***) **MMR** Date:_____	**Signature:**_____ **Date Signed:**_____ **Stamp:**
Varicella Titer **TITER REQUIRED**	**Titer Date:**_____ **Immune** Yes:_____ No:_____ (***If "No" vaccine is needed***)	Varicella Vaccine (***If titer is not immune***) **Varicella** Date:_____	**Signature:**_____ **Date Signed:**_____ **Stamp:**
Hepatitis B Titer **TITER REQUIRED**	**Titer Date:**_____ **Immune** Yes:_____ No:_____ (***If "No" vaccine is needed***)	Hepatitis B Vaccine (***If titer is not immune***) **Hep B #1**:_____ **Hep B #2**:_____ **Hep B #3**:_____	**Signature:**_____ **Date Signed:**_____ **Stamp:**
Tdap Immunization (**within 10 years**)		Tdap Vaccine Required **Tdap** **Date:**_____	**Signature:**_____ **Date Signed:**_____ **Stamp:**
Flu Shot (**required for current year**)		Flu Shot Required **Flu Shot** **Date:**_____	**Signature:**_____ **Date Signed:**_____ **Stamp:**
TB Test (**within 90 days of the program**)	**Date Given:**_____ **Date Read:**_____ **Reaction** Positive:_____ Negative: ____ _____mm induration	Chest X-Ray (***If PPD is positive***) **Result Date:**_____ Positive:_____ Negative:____	**Signature:**_____ **Date Signed:**_____ **Stamp:**