Confidential Health Certificate
Health History and Medical Record
DHS EMS 1 and 2

Name: _____ Student ID#: _____

Maiden Name: _____ Phone #: _____

Address: _____

Certification Course: _____ Date of Entry: _____

Name of person to be notified in emergency: _____

Phone #: _____ Relationship: _____

HEALTH HISTORY
(To be Completed by Student)

DO YOU HAVE:	**YES**	**NO**		**YES**	**NO**
Alcohol/Drug Dependency	( )	( )	G.I. Problems	( )	( )
Allergic Reaction	( )	( )	Joint Disease	( )	( )
Asthma	( )	( )	Kidney Disease	( )	( )
Diabetes	( )	( )	Rheumatic Fever	( )	( )
Difficulty with Coordination	( )	( )	Seizure disorder	( )	( )
Emotional Disorder	( )	( )	Severe Hearing Loss	( )	( )
Heart Disease	( )	( )	Vision that cannot be		
Back Problems	( )	( )	corrected with glasses	( )	( )
Surgery within last year	( )	( )	Tuberculosis	( )	( )
Hospitalization within the past five years?	( )	( )	Any other health problem		
Other: _____			not listed here?	( )	( )

Do you take any medications on a regular basis? ( ) ( )

Please explain all YES answers._____

_____

N95 Fit Test: Model: _____ Size: _____

Fit Test Examiner (Print Name): _____ Signature: _____

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Required Two-Step Mantoux PPD: (second test 1-3 weeks after 1st PPD or 1st PPD within the year & 2nd PPD must be current)

Date Given: _____ Date Read: _____ Result: _____ Signature: _____

Date Given: _____ Date Read: _____ Result: _____ Signature: _____

OR

QuantiFERON®-TB Gold: Date: _____ Results: _____ Signature: _____

For a positive PPD: A Chest X-ray is required (submit copy of radiological report).

Date: _____ Result: _____

* An annual symptom screen must be completed every year.
* Repeat Chest X-rays are only necessary if the symptom screen is positive.

Positive PPD Symptom Screen

Does the patient have:

	YES	NO		YES	NO
Feelings of sickness	( )	( )	Night sweats	( )	( )
Weakness	( )	( )	Coughing	( )	( )
Weight loss	( )	( )	Chest pain	( )	( )
Fever	( )	( )	Coughing up blood	( )	( )

B. Required **IGG** Titers (**attach copy of lab reports**)*

Measles (IGG): _____ Mumps (IGG): _____ Rubella (IGG): _____ Varicella (IGG): _____
Date Date Date Date

*All negative or equivocal IGG titer results require immunization and a repeat titer. ***(This means that if the titer is not positive, you must receive the corresponding immunization(s) and a repeat titer 2-3 months after re-immunization.)***

C. Required Hepatitis B – Satisfy either 1 or 2 below

1. Titer (Hepatitis B surface Ab) results showing immunity (attach copy of lab report).

Date of Titer: _____ Result: _____
(If negative, hepatitis B vaccination is required until proof of immunity can be confirmed)

OR

2. Signed waiver to accompany this form.

D. Required Tdap (Tetanus/Diphtheria/Pertussis) Immunization within 10 Years:

Name of Immunization: _____ Date: _____

E. *Clinical Requirements for Hospital Rotations – Required Vaccines "Influenza and COVID-19"

1. Influenza Vaccine: Lot #: _____ Expiration Date: _____

2. COVID-19 Vaccine: Copy of verification of COVID-19; and if required, COVID-19 boosters.

F. Physical Examination – must be done annually (***ALL AREAS MUST BE COMPLETED***)

Height: _____ Weight: _____ Skin: _____
Ears R: _____ L: _____ Lymph Nodes: _____
Vision (with glasses) R: _____ L: _____ Nose: _____
Teeth: _____ Throat: _____
Thyroid: _____ Lungs: _____
Blood Pressure: _____ Heart: _____
Abdomen: _____ Hernia: _____
Neurological Exam: _____
Extremities: _____
Previous Psychiatric Treatment: _____

G. Health Care Provider's Statement:

☐ "I performed the above medical evaluation and found, to the best of my knowledge, they are to be free from physical or mental impairment including habituation or addiction to depressants, stimulants, narcotics, alcohol, or other behavior-altering substances which might interfere with the performance of their duties or would impose potential risk to patients or personnel."

☐ "The following active problems were identified, which might interfere with the performance of his/her duties."
_____
_____

_____
Health Care Provider's Signature

_____ _____
Date Phone Number **Physician/Office/Agency Stamp**

Form will not be accepted without Physicians Stamp! (Rev. 11/23
***Please attach proof of Influenza and COVID-19 vaccines.**

Confidential Health Certificate
Hepatitis B Vaccination Declination Form

Student: _____

BBP Course #: _____ NYS Course #: _____

Course Location: _____

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection.

I am aware that although the BBP Services Emergency Medical Services (EMS) Division does not require Hepatitis B vaccination for completion of the Division's New York State Emergency Medical Technician – Basic original course, most contracted hospitals make it a condition of completing clinical time at their location.

By signing this form I am declining the Hepatitis B vaccination series with the full understanding that by doing so I may put myself at risk for contracting Hepatitis B.

Student Signature: _____ Date: _____