HEALTH PROFESSIONS Physical Examination Form

Part I **APPLICANT:** Complete this section before visiting the doctor. Please **PRINT.**

PROGRAM check one: _____ Emergency Medical Services

☐ Critical Care ☐ EMT ☐ AEMT

Name _____
First MI Last

Address _____
Street City State Zip Code

SSN (last 4) _____ Birth date ____/____/____
Month Day Year

Telephone _____ _____
(Primary) (Secondary)

Student E-mail _____ Secondary E-mail _____

NOTE: The student is required to maintain health insurance and/or be responsible for medical expenses incurred during a clinical rotation or feld internship.

I request that this report be submitted to the Course Coordinator/ Program Director at For Life Medical Education Services, Incorporated, Business Office: 10710 White Bluff Road, Savannah, GA 31406; Education Building.

I hereby attest that medical information supplied includes all medical conditions that would affect my participation in a health professions program. I authorize release of current medical information on my medical history or current condition to clinical affliates.

If false information is given, or if signifcant medical information is withheld, I understand I will be dismissed from the program.

Applicant Signature: _____ Date: _____

HEALTH PROFESSIONS Physical Examination Form

Part II

INSTRUCTIONS: Physician or offcial designee must complete parts II, III, IV, and V of this form and affx his/her offcial stamp at the bottom of the last page. Copies of lab reports, vaccination records, and titers, **MUST** be attached.

PHYSICIAN:

Please complete **all sections** of this form and return to **patient.**

1. Height: ____
2. Weight: ____
3. T:_____P:_____R: BP:_____/_____ OTBS: _____
4. Vision: OD_____OS_____OU_____Corrected?____Yes____No
5. General appearance: _____
6. Ears: _____
7. Nose: _____
8. Throat: _____
9. Neck: _____
10. Chest: _____
11. Cardiovascular system: _____
12. Abdomen: _____
13. GI system: _____
14. GU system: _____
15. CNS/Refexes: _____
16. Back: _____
17. Fine Motor Control: _____
18. Is there evidence of current misuse of illicit drugs or alcohol: ___Yes_____No
19. Describe any conditions currently being treated:
    _____
    _____
    _____
    _____
    _____
20. Allergies: _____

Applicant Name: _____

HEALTH PROFESSIONS Immunization Record

Part III

PHYSICIAN: The following immunizations or titers are required. A shot record must document all immunizations/titers unless immunization is given the day of the physical exam. **In addition to completing the physical form please provide a copy of all immunology results & titer results.** Express results in numerical values.

TB skin test
PPD

Applicant must undergo a two-step PPD* prior to beginning the clinical experience.

*The second PPD should be completed 7-10 days after the frst test is completed.

If PPD is positive, then a chest X-Ray must be obtained.

Copy of the x-ray report must be attached.

PPD	Date	Results in mm
1st PPD	/ /	
2nd PPD	/ /	
Chest X-Ray	/ /	
Gamma Release	/ /	
Assay (T-Spot)		
Follow Up	/ /	

Mumps
Rubeola
Rubella
MMR

The applicant must have documented proof of immunity shown by mumps, rubeola, and rubella titers, or proof of two (2) MMR vaccinations.

If the applicant is not immune to MMR, they are required to obtain two (2) MMR vaccinations.

Please note: To reduce expense an MMR vaccination may be given in place of titer levels.

MMR	Date	Titer Results
Mumps titer	/ /	
Rubeola titer	/ /	
Rubella titer	/ /	
1st MMR injection	/ /	
2nd MMR injection	/ /	
MMR Booster	/ /	

Varicella
Chicken Pox

The applicant must have documented proof of immunity shown by **Varicella titer,** or proof of two (2) Varicella vaccinations.

If the applicant is not immune to Varicella, they are required to obtain two (2) Varicella vaccinations.

Note: Proof of childhood illness is NOT documentation of immunity.

Varicella	Date	Titer Results
1st Varicella injection	/ /	
2nd Varicella injection	/ /	
Varicella Booster	/ /	

Hepatitis B

Several clinical sites may require the completed Hepatitis B immunization series prior to beginning clinicals, or show documented immunity verifed by Hepatitis titer levels.

Hepatitis B	Date	
1st Hepatitis injection	/ /	
2nd Hepatitis injection	/ /	1 month
3rd Hepatitis injection	/ /	6 months
Hepatitis Titer	/ /	(titer)
Hepatitis Booster	/ /	

Tdap

The health professions programs require that applicants have a current tetanus toxoid vaccination ***within the past 10 years.***

Tdap	Date
Tdap injection	/ /

Flu Shot

The health professions programs require applicants to have a current seasonal fu shot.

Flu Shot	Date
Flu Shot injection	/ /

Applicant Name: _____

HEALTH PROFESSIONS Technical Standards

Part IV

To ensure patient safety and welfare, the Emergency Medical Services Programs of For Life Medical Education Services, Incorporated has established technical standards which must be met by the applicants.

PHYSICIAN: Please consider the following technical standards when answering question number four (4) in Part V of the Physical Form.

YES	NO	
____	____	**Sufficient eyesight** to observe patients, read patient records, manipulate equipment and accessories, visually monitor patients in dimmed light via video monitors, assess patients in low-light environments and establish patent intravenous access.
____	____	**Sufficient hearing** to communicate with patients and other members of the health care team, monitor patients via audio monitors, and hear background sounds during equipment operations.
____	____	**Satisfactory speaking, reading, listening and writing skills** to effectively and promptly communicate in English.
____	____	**Sufficient gross and fine motor coordination** to manipulate equipment and accessories, lift a minimum of 50 pounds and to stoop, bend or promptly assist patients who become unstable and establish patent Intravenous access.
____	____	**Satisfactory physical strength and endurance** to move immobile patients to or from a stretcher or wheelchair to the x-ray table, work with arms extended overhead, stand in place for long periods of time, and carry 20-25 pounds while walking. EMS applicants must be able to lift, carry, and balance 150 pounds.
____	____	**Satisfactory intellectual and emotional functions** to ensure patient safety and exercise independent judgment and discretion in the performance of assigned responsibilities.

Remarks:

Applicant Name: _____

HEALTH PROFESSIONS Physical Examination Form

Part V

PHYSICIAN: Fill in pertinent information regarding applicant including comments where required.

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1. Is there anything in the applicant's past medical history that would preclude his/her successful completion of a health professions program? **YES** **NO**

If yes, please explain:

____ ____

2. After reviewing the questions in Part IV on the previous page, does this person have any physical or mental condition or disability, which would prevent him/her from attending this program? **YES** **NO**

If yes, please explain:

____ ____

3. Applies **ONLY to Emergency Medical Services Applicants:** After examination, does this applicant have any evidence of illness or injury which would prohibit participation in clinical or internship components including use of an OSHA approved HEPA respirator? **YES** **NO**

If yes, please explain:

____ ____

4. Applies **ONLY to Emergency Medical Services:** **DOES NOT MEET** **MEETS**

Does this person meet the technical standards indicated in Part IV for the program to which he/she is applying?

If it does not meet, please explain:

_____ ____ ____

_____

_____

_____

_____

I have, this date, given _____ a careful physical examination and found him/her

to be in _____ health. Date: ____/____/ ____

Signature: _____ M.D., or ***offcial*** designee.

_____ M.D. or ***offcial*** designee.
Print

_____
Address

_____
City State Zip

_____
Telephone

Place Official Stamp Below

Applicant Name: _____