



Moreno Valley College



EMT 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 performing 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 performing 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
MMR Titer TITER REQUIRED	Titer Date: _____ Immune Yes: _____ No: _____ <i>(If "No" vaccine is needed)</i>	<u>MMR Vaccine</u> <i>(If titer is <u>not</u> immune)</i> MMR Date: _____
Varicella Titer TITER REQUIRED	Titer Date: _____ Immune Yes: _____ No: _____ <i>(If "No" vaccine is needed)</i>	<u>Varicella Vaccine</u> <i>(If titer is <u>not</u> immune)</i> Varicella Date: _____
Hepatitis B Titer TITER REQUIRED	Titer Date: _____ Immune Yes: _____ No: _____ <i>(If "No" vaccine is needed)</i>	<u>Hepatitis B Vaccine</u> <i>(If titer is <u>not</u> immune)</i> Hep B #1: _____ Hep B #2: _____ Hep B #3: _____
Tdap Immunization (Within 10 years)		<u>Tdap Vaccine Required</u> Tdap Date: _____
Flu Shot (Required for current year)		<u>Flu Shot Required</u> Flu Shot Date: _____
TB Test (Within 90 days of the program)	Date Given: _____ Date Read: _____ Reaction Positive: _____ Negative: _____ _____ mm induration	<u>Chest X-Ray</u> <i>(If PPD is <u>positive</u>)</i> Result Date: _____ Positive: _____ Negative: _____

Student Name: _____ Student ID #: _____

	Or QuantiFERON: Negative: _____ Positive: _____	
Polio Vaccine (RUHS Requirement)	<i>Need to have documentation of Immunization Series- these can be from childhood immunization record. If never received, need to have the Polio Series.</i>	Dates Given: #1 _____ #2 _____ #3 _____

Health Provider's Attestation to the above Immunizations and Titters

Signature: _____

Date Signed: _____

Stamp:

****Please provide a **COPY** of your blood titers with this health record. Only checking **IMMUNE** is **NOT** sufficient for your medical clearance at the clinical facilities.