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Health Examination Report

Last Name	First Name	MI	Date

I understand that health information is protected and confidential under State of Ohio and federal laws. I voluntarily provide and consent to my medical provider or physician providing the medical information contained in this document to Grant EMS Education and understand that admission is contingent upon a physical exam including the Health Examination Report. Failure to complete this record will prevent my participation in the clinical/field program. My health care provider (MD, DO, PA, ARNP) must sign in the appropriate spaces provided on the form. Documentation of all titers, skin testing, and x-rays must be attached to the student health record.

SECTION 1: PERSONAL INFORMATION

All areas of this section must be completed. This information will be kept on file and used in the event that the student must be contacted or an emergency contact is required.

SECTION 2: REQUIRED INFLUENZA INJECTION (FLU SHOT)

Students participating in a clinical/field rotation must receive the influenza injection. Students that cannot participate in the influenza injection process as a result of a medical condition or religious beliefs may be required to participate in additional measures established by Grant EMS Education. Additionally, it may jeopardize the student's ability to participate in the clinical/field portion of the program. It is highly recommended that all students receive the influenza injection.

SECTION 3: REQUIRED TITERS/TESTS

A **Varicella (Chicken Pox):** A Varicella Titer must be drawn and ***the results attached.*** **A record of the Varicella Vaccine will not be accepted as documentation of the required titer.** The date of the titer and results must be indicated in the appropriate area. **(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).**

Mumps, Rubeola (Measles), and Rubella (German Measles): A Mumps, Rubeola, and Rubella Titer must be drawn and ***the results attached.*** **A record of the MMR (Mumps, Measles, Rubella) Vaccine will not be accepted as documentation of the required titer.** The dates of the titers and the results must be indicated in the appropriate area. **(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).**

B **TB Skin Test:** Two consecutive TB Skin Tests are required. The TB Skin tests can be repeated a minimum of three days apart. ***The dates and results of each TB Skin Test must be attached.*** The Skin Tests must have been performed within the last three (3) months to be considered a recent test. ***In the event the results indicate a positive skin test or the student has a history of a positive TB skin test, a chest x-ray is required.***

Chest X-ray: A recent Chest x-ray is required if a positive TB skin Test is reported or there is a history of a positive TB Skin Test. The chest x-ray must have been completed within the last three (3) months to be considered current. ***Results must be attached.***

SECTION 4: HEPATITIS B VACCINE

Students must provide documentation of the initiation or completion of the Hepatitis B vaccine series at the time of application. It is highly recommended that the student complete the series while enrolled in the program. However students may decline the vaccine. A decline attestation is found on page 3. **A record of the Hepatitis B Vaccine or antibody test results must be attached.**

SECTION 5: STUDENT'S STATEMENT

Student must read and sign this statement on page 3 of the Student Health Record

SECTION 6: EXAMINER'S STATEMENT

The Health Care Examiner (MD, DO, PA, and ARNP) must read, sign, and confirm that the student can meet the Physical Demands associated with the program in the Examiner's Statement Area on page 4 of the Student Heath Record.

Please Place Health Care Provider Office Stamp or Attach Business Card Here (Required):

SECTION 1: PERSONAL INFORMATION

Street Address			Email Address	
City			State	Zip
Date of Birth	Home Number	Cell Number	Gender	
Name of Emergency Contact		Relationship	Contact Number	

SECTION 2: INFLUENZA INJECTION

Date of Injection / /	I understand that if I cannot participate in the influenza injection process as a result of a medical condition, religious beliefs, or otherwise refuse to participate in the influenza injection, I may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize my ability to participate in the clinical portion of the program.
Student Signature	Date

SECTION 3: REQUIRED TITERS/TESTS

Parts A and B ARE TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY

A. **REQUIRED TITERS:** (Documentation must be attached) A Varicella, Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn and the results attached. **A record of Vaccines WILL NOT BE ACCEPTED as documentation for the required titers.** The dates of the titers and the results must be indicated in the appropriate area below. **(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).**

TITER	DATE	LAB RESULTS Documentation must be attached Numerical Value of Results Must Be Reported	PLEASE CIRCLE
Varicella Titer	______/______/ ______		**Immune/ Not Immune**
Mumps Titer	______/______/ ______		**Immune/ Not Immune**
Rubeola (Measles) Titer	______/______/ ______		**Immune/ Not Immune**
Rubella (German Measles) Titer	______/______/ ______		**Immune/ Not Immune**

B. TB SKIN TEST/CHEST X-RAY: Two consecutive TB Skin Tests are required. ***The TB Skin tests can be repeated a minimum of three days apart.*** The dates and results of each TB Skin Test must be attached. The Skin Tests must have been performed within the last three (3) months to be considered a recent test. **In the event the results indicate a positive skin test or the student has a history of a positive TB skin test, a chest x-ray is required. The chest x-ray must have been completed within the last three (3) months to be considered current. Results must be attached.**

TEST	DATE		RESULTS
TB Skin Test 1st Test	______/______/ ______	**Positive □ Negative □**	**If positive skin test, current chest x-ray is required. Results of TB skin test must be attached.**
TB Skin Test 2nd Test	______/______/ ______	**Positive □ Negative □**	**If positive skin test, current chest x-ray is required. Results of TB skin test must be attached.**

Chest X-ray	______/______/ ______	Positive □ Negative □	RESULTS OF CHEST X-RAY MUST BE ATTACHED

SECTION 4: HEPATITIS

Introduction: Health care professionals are at risk of exposure to blood and body fluids contaminated with the viruses that cause HIV and Hepatitis. Consistent use of Standard Precautions is the best known means to avoid transmission of these viruses or other contaminants. Students will be taught Standard Precautions before they provide care to any patient in the clinical setting. Although it is rare, a health care worker may become exposed to one of these viruses through accidental transmission. Currently, there is no vaccine that protects against the HIV virus. However, the Hepatitis B vaccine is an effective means of preventing Hepatitis B. As a student who will be providing direct patient care, you should discuss this vaccine with your health care provider

About the Vaccine: The Hepatitis B Vaccine is a genetically engineered "yeast" derived vaccine. It is administered in the deltoid muscle (arm) in a series of three doses over a six month period. You should seek additional information about the vaccine from your health care provider; especially if you have an allergy to yeast or may be pregnant, or are a nursing mother.

I have initiated the Hepatitis B Vaccine Series with my first dose listed below:

1st Dose Date:______/______/ ______ **2nd Dose Date:______/______/ ______** **3rd Dose Date______/______/ ______**
(One month after 1st dose) **(Six month after 1st dose)**

OR

I have already completed a Hepatitis B Vaccine Program with dates of injections listed below:

1st Dose Date:______/______/ ______ **2nd Dose Date:______/______/ ______** **3rd Dose Date______/______/ ______**
(One month after 1st dose) **(Six month after 1st dose)**

OR

Antibody testing has revealed that I have immunity to Hepatitis B. Yes □ No □ **(ATTACH COPY OF LAB REPORT).**

OR

I understand that, due to my occupational exposure to blood or other potentially infectious materials, I am at risk of acquiring Hepatitis B infection. I understand that the Hepatitis B Vaccine is recommended to help prevent illness due to the Hepatitis B Virus. I have discussed the risks and benefits with my personal health care provider and ***decline*** the Hepatitis B Vaccine at this time.

Student Signature	Date

SECTION 5: STUDENT'S STATEMENT

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the **Health Examination Report** to Grant EMS Education and any health care facility in which I am assigned for on-site clinical training. I understand that my personal health information is required to facilitate my participation in the clinical training, which is required for program completion. I also hereby release and hold harmless Grant Medical Center and receiving health care facilities from any claim of violation of HIPAA or any other medical privacy rights that may arise for the release of my personal health information provided in the **Health Examination Report**.

Print Name	
Student Signature	Date

HISTORY AND PHYSICAL EXAM

Height	Weight	L Eye	R Eye	Both	Corrective Lenses Yes ☐ No ☐

Head	
Ears / Nose / Throat	
Neck	
Chest / Lungs	
Heart	
Abdomen	
Extremities	
Back	
History of Any Chronic Illness	
List All regular Medications	

Any Physical Limitations?			
Standing **Yes ☐ No ☐**	**Pushing** **Yes ☐ No ☐**	**Crawling** **Yes ☐ No ☐**	**Feeling** **Yes ☐ No ☐**
Walking **Yes ☐ No ☐**	**Pulling** **Yes ☐ No ☐**	**Stooping** **Yes ☐ No ☐**	**Talking** **Yes ☐ No ☐**
Sitting **Yes ☐ No ☐**	**Balancing** **Yes ☐ No ☐**	**Kneeling** **Yes ☐ No ☐**	**Hearing** **Yes ☐ No ☐**
Lifting (up to 125 pounds) **Yes ☐ No ☐**	**Climbing** **Yes ☐ No ☐**	**Reaching** **Yes ☐ No ☐**	**Seeing** **Yes ☐ No ☐**
Carrying **Yes ☐ No ☐**	**Crouching** **Yes ☐ No ☐**	**Manual Dexterity** **Yes ☐ No ☐**	**Communicating** **Yes ☐ No ☐**

SECTION 6: EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this document and that the information about the test results are correct. This individual can participate in all activities required to provide health care to patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the designated health care program. The student is able to meet THE PHYSICAL DEMANDS that are listed above. (list any limitations associated with this student in the area provided).

MD/DO/PA/ARNP Signature	Date
Office Telephone Number	License Number