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 corrected with glasses	( )	( )
Back Problems	( )	( )	Tuberculosis	( )	( )
Surgery within last year	( )	( )	Any other health problem not listed here?	( )	( )
Hospitalization within the past five years?	( )	( )	Other _____		
Do you take any medications on a regular basis?	( )	( )			

Please explain all YES answers._____

_____

_____

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/Diptheria/Pertussis) Immunization within 10 Years:

Name of Immunization _____ Date _____

E. Required Flu Vaccine (annual): - Satisfy either 1, or 2 below:

1. Influenza Vaccine: Lot #_____ Expiration date _____

2. Signed waiver to accompany this form to acknowledge that they must wear a mask in all patient care areas.

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, him/her 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 his/her 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. 12/17)

Confidential Health Certificate
Hepatitis B Vaccination Declination Form

Student: _____

Suffolk County 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 Suffolk County 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 Suffolk County 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: _____