



**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)**

<u>DO YOU HAVE:</u>	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
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:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
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. 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"

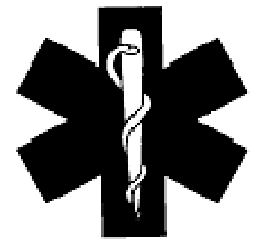
Health Care Provider's Signature

Date

Phone Number

Physician/Office/Agency Stamp

Form will not be accepted without Physicians Stamp!



**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: _____