PHYSICIAN STATEMENT & RELEASE
DHS-EMS 2

Name of Student:_____ Ambulance/Fire Agency_____

Address:_____

_____

Student's Telephone number(s): Day_____ Evening _____

Student's Date of Birth:_____

Physician's Statement - "I have performed a medical evaluation and reviewed the student's Health History. I have the Student's Health History & Medical Record (DHS-EMS1) on file. I found the above named student, to the best of my knowledge, to be free from physical or mental impairments 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 a potential risk to patients or personnel."

The following immunizations, history or tests have been completed or confirmed:

Measles	Yes ( )	No ( )	
Chickenpox	Yes ( )	No ( )	
Rubella	Yes ( )	No ( )	
Hepatitis B	Yes ( )	No ( )	
PPD	Yes ( )	No ( )	
Tetanus booster	Yes ( )	No ( )	
Diptheria	Yes ( )	No ( )	
Influenza Vaccine**	Yes ( )	No ( )	If yes, please put date. _____
H1N1 Influenza Vaccine**	Yes ( )	No ( )	If yes, please put date. _____

_____ _____

Physician's Name (Please print) Physician's Signature

_____ _____ PHYSICIAN'S STAMP:

Date Phone Number

_____

Address

I hereby authorize the above named physician to furnish my Health History and Medical Record (DHS-EMS1) to the Department of Health Services, Division of EMS and for the Department of Health Services, Division of EMS to furnish a copy of this Health History & Medical Record to any hospital, or other designated clinical site(s) required by my training.

_____ _____ _____

Print Name of Student Signature of Student Date

****If available at the time of the physical.**

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