



Newark • Coshocton • Knox • Pataskala

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Health Examination Report

Form with fields: 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 Central Ohio Technical College and understand that admission is contingent upon a physical exam including the Health Examination Report.

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.

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, Rubella (Measles), and Rubella (German measles): A Mumps, Rubella, and Rubella Titer must be drawn and the results attached. A record of the MMR (Mumps, Measles, and 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 2-Step 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 provided. A record of the Hepatitis B Vaccine or antibody test results must be attached.

SECTION 5: Tdap VACCINE (Tetanus-Diphtheria-Pertussis)

Students must provide documentation of the Tdap vaccine in the last 10 years at the time of application. A record of the Tdap vaccination must be attached.

SECTION 6: STUDENT'S STATEMENT

Student must read and sign this statement of the Student Health Record

SECTION 7: 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 Health 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	
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 medical condition, religious beliefs, or otherwise refuse to participate in the 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. (current prior to the start of clinicals)
Student Signature	Date

SECTION 3: REQUIRED TITER/TESTS

Parts A and B are to be completed by Authorized 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.

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. **2-STEP TB SKIN TEST/CHEST X-RAY:** Two consecutive TB Skin Tests are required.

TEST	DATE		RESULTS
TB Skin Test 1 st Test	____/____/____	Positive <input type="checkbox"/> Negative <input type="checkbox"/>	If positive skin test, current chest x-ray is required. <u>Results of TB test must be attached.</u>
TB Skin Test 2 nd Test	____/____/____	Positive <input type="checkbox"/> Negative <input type="checkbox"/>	If positive skin test, current chest x-ray is required. <u>Results of TB test must be attached.</u>
Chest X-Ray	____/____/____	Positive <input type="checkbox"/> Negative <input type="checkbox"/>	RESULTS OF CHEST X-RAY MUST BE ATTACHED

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___	
Sitting Yes___ No___	Pulling Yes___ No___	Stooping Yes___ No___	Talking Yes___ No___	Balancing Yes___ No___	
Kneeling Yes___ No___	Hearing Yes___ No___	Carrying Yes___ No___	Crouching Yes___ No___	Manual Dexterity Yes___ No___	
Lifting (up to 125 pounds) Yes___	Climbing Yes___ No___	Reaching Yes___ No___	Seeing Yes___ No___	Communicating Yes___ No___	

SECTION 5: 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 patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the EMS/Paramedic 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