



## **EMS EDUCATION STUDENT IMMUNIZATION AND PHYSICAL EXAM REQUIREMENTS**

An accurate Student Self-report Health Form is essential and enables AOMC to provide appropriate care and guidance to students. It is considered a CONFIDENTIAL document. All students who plan to enter the program must complete this health form. All students are required to have a physical examination by their healthcare provider and provide documentation of the identified immunizations/screenings **BEFORE** beginning the course.

According to Public Health Laws 2165 and 405.3 Title 10 NYCRR, students attending colleges or universities and affiliating with a Health Care Facility, must meet certain minimum health requirements. In addition, OSHA requires anyone exposed to blood or body fluid be given education and offer of Hepatitis B vaccine. Therefore, it is mandatory that the following forms (Student Immunization Assessment and Student Health History/Health History and Physical) be completed and returned to your instructor within three weeks of the start of the class. Failure to complete these requirements will result in withdrawal from the course.

Read the information enclosed very carefully. It is your responsibility to make sure that all areas are completed within the time frame given!!

For records of immunization history:

- Check with personal physician.
- Check with High School from which you graduated.
- Check with your "employee health" office where you work.

You may have a blood test done to determine whether or not you have immunity against measles, mumps, or rubella. Check with personal physician for this.

In the event you need measles, mumps, or rubella vaccinations and or PPD test, you may:  
Obtain through your personal physician.  
Receive them through your County Health Department.

In the event you wish to receive the Hepatitis B vaccine, you may:  
Obtain through your personal physician.  
Contact your ambulance corps president or your fire department chief.

### **COMMON QUESTIONS ABOUT HEALTH REQUIREMENTS**

Who has to meet health requirements?

Any and all students are required to complete clinical observation time within a health care facility.

If you were born before January 1, 1957, you do not have to get any measles vaccines; but you need to complete all of the rest of the requirements.

If you were born on or after January 1, 1957, you need to complete all of the requirements.

If I am refreshing my EMT, do I have to complete the health requirements?

No, unless you expect to complete clinical observation time. Check with your instructor.

Can I refuse any of the health requirements?

The only vaccine that you can refuse is the Hepatitis vaccine (if refusing, complete **HEPATITIS B VACCINE DECLINATION FORM**). The only way any other vaccine requirement can be waived is if you have a medical exception. This means that your physician must sign a statement, stating the reason that he/she does not want you to get the vaccine.

Why do I have to do this?

It is mandated by the New York State Department of Health that hospitals be able to prove that any person who comes in contact with patients meets these minimum health requirements. This includes volunteers and students.

What if I do not have or cannot find documentation of any "shots" when I was a child? You will have to complete the series of measles, mumps and rubella again or you can ask your doctor to order lab tests to determine immunity.

Does my baby book qualify as documentation?

No, unless it was signed by your physicians at the time of the immunization.

Would my school records count as documentation?

Yes, obtain a copy and send it with your forms. Please make sure that it is a clear, legible copy.

Why does a measles vaccine given before 1968 not qualify?

Prior to 1968, physicians had a choice of either giving a "live" vaccine or a synthetic vaccine. It was determined that the synthetic vaccines were not effective; therefore, unless there is specific information that states it was a "live" vaccine, they are not counted towards the required two vaccines.

How much time between each measles vaccine must I wait if I have to receive two doses?

The minimum time between each dose is 30 days.

What is a PPD?

A PPD is a skin test to determine whether or not you have been exposed to tuberculosis . It is administered on the inside of your forearm and must be read between 48 and 72 hours after administration. The reading must be signed and dated by a health practitioner.

If I have a positive reaction to the PPD, does it mean I have tuberculosis?

No, It indicates that you might have been exposed to the disease. You will be required to have a chest x-ray.

Do I have to get the Hepatitis vaccine in order to get into the hospital?

No. You need only to be educated (as with a film) and may elect to refuse the vaccine.

If I refuse the vaccine, and change my mind later, can I still get the vaccine? Absolutely. The hospitals need only to know that, at the time of your clinical rotation that you know the risks of contracting hepatitis and are aware that there is a vaccine available. You may change your mind at any time and receive the vaccine.

\*\*\*ANY FURTHER QUESTIONS, CONTACT EMSTAR 607-732-2354\*\*\*

## EMS EDUCATION STUDENT SELF-REPORT HEALTH FORM

**DIRECTIONS: ANSWER ALL QUESTIONS. CHECK WHERE APPLICABLE**

### 1. Family History

Father: Age \_\_\_\_\_

Mother: Age \_\_\_\_\_

If either parent is deceased, identify and give cause \_\_\_\_\_  
\_\_\_\_\_

### 2. Among your blood relatives, is there a present or past history of:

- \_\_\_ Heart Disease
- \_\_\_ High Blood Pressure
- \_\_\_ Stroke
- \_\_\_ Tuberculosis
- \_\_\_ Diabetes
- \_\_\_ Cancer
- \_\_\_ Anemia
- \_\_\_ Allergies
- \_\_\_ Seizures
- \_\_\_ Kidney Disease
- \_\_\_ Arthritis/Gout
- \_\_\_ Stomach, Intestinal Problems
- \_\_\_ Emotional Problems
- \_\_\_ Cirrhosis
- \_\_\_ Migraine
- \_\_\_ Deafness
- \_\_\_ Blindness

### 3. Are you allergic to any of the following:

- \_\_\_ Penicillin
- \_\_\_ Sulfa
- \_\_\_ Horse Serum
- \_\_\_ Insect bites, Stings
- \_\_\_ Other Medicines

Specify \_\_\_\_\_  
\_\_\_\_\_

\_\_\_ Other Substances  
Specify \_\_\_\_\_  
\_\_\_\_\_

### 4. Have you ever had, or do you have:

- \_\_\_ Hay Fever
- \_\_\_ Hives
- \_\_\_ Eczema

### 5. Have you ever had: (optional)

\_\_\_ Surgery  
Describe \_\_\_\_\_  
\_\_\_\_\_

### 6. Have you had, or do you have:

- \_\_\_ Rheumatic Fever
- \_\_\_ Heart Problems
- \_\_\_ Asthma/Lung/Bronchial Disease
- \_\_\_ Hypertension
- \_\_\_ Diabetes
- \_\_\_ Kidney Disease
- \_\_\_ Bladder Disease
- \_\_\_ Ulcer
- \_\_\_ Intestinal Disease
- \_\_\_ Hepatitis
- \_\_\_ Frequent Indigestion
- \_\_\_ Frequent Diarrhea
- \_\_\_ Sexually Transmitted Disease
- \_\_\_ Frequent Sleep Problems
- \_\_\_ Frequent Appetite Problems
- \_\_\_ Frequent Breathing Problems
- \_\_\_ Persistent Nervousness
- \_\_\_ Persistent Anxiety/Depression
- \_\_\_ Recent gain or loss of weight of 10 pounds or more
- \_\_\_ Joint Injury (severe)
- \_\_\_ Arthritis/Joint Disease
- \_\_\_ Shoulder Dislocation
- \_\_\_ Knee Problems
- \_\_\_ Back Problems
- \_\_\_ Broken Bones
- \_\_\_ Head Injury (with unconsciousness)
- \_\_\_ Concussion
- \_\_\_ Seizures/Blackouts
- \_\_\_ Meningitis/Encephalitis
- \_\_\_ Weakness/Paralysis
- \_\_\_ Frequent Headaches
- \_\_\_ Mumps
- \_\_\_ German Measles (Rubella)
- \_\_\_ Measles (Rubeola)
- \_\_\_ Mononucleosis
- \_\_\_ Chicken Pox
- \_\_\_ Malaria
- \_\_\_ Other Tropical Diseases
- Specify \_\_\_\_\_
- \_\_\_ Anemia
- \_\_\_ Sickle Cell Disease
- \_\_\_ Hemophilia or other
- \_\_\_ Bleeding Problems

### FOR FEMALES:

- \_\_\_ Chronic Vaginal Infections
- \_\_\_ Irregular Menses (Period)
- \_\_\_ Excessive Bleeding with Menses (Period)

### DISABILITY (Optional) A disability is a problem that cause long-term impairment of your ability to work or function. Do you have a disability?

- \_\_\_ Yes
- \_\_\_ No

Specify:

- \_\_\_ Speech
- \_\_\_ Chronic Illness
- \_\_\_ Mobility Impairment
- \_\_\_ Visual
- \_\_\_ Hearing
- \_\_\_ Emotional
- \_\_\_ Substance Misuse
- \_\_\_ Learning

Would you like your name given to the Disability Services Office and/or your academic advisor to discuss accommodations:

- \_\_\_ Yes
- \_\_\_ No

Student Name \_\_\_\_\_

## EMS EDUCATION PHYSICAL

### PHYSICAL EXAMINATION:

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Significant History:

---

---

---

Present Medication(s) Requirements:

---

---

---

CLINICAL EVALUATION:	Normal	Abnormal	Remarks
Eyes	_____	_____	_____
Head, Ears, Nose, Throat	_____	_____	_____
Teeth	_____	_____	_____
Skin	_____	_____	_____
Respiratory System	_____	_____	_____
Cardiovascular System	_____	_____	_____
Gastrointestinal System	_____	_____	_____
Genitourinary System	_____	_____	_____
Metabolic Endocrine System	_____	_____	_____
Musculoskeletal System	_____	_____	_____
Neuropsychiatric System	_____	_____	_____

Vision Testing: Left \_\_\_\_\_ Right \_\_\_\_\_ Recommendation: \_\_\_\_\_

Lab Results: SMA 12 \_\_\_\_\_ CBC \_\_\_\_\_ UA \_\_\_\_\_

DETAILS OF ABNORMALITIES: (Please review any abnormalities with student)

---

---

Do you have any special instructions (restrictions, medications, recommendations) concerning this student?

---

---

Healthcare Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

## EMS EDUCATION IMMUNIZATIONS

PPD required annually

TUBERCULIN SKIN TEST: PPD (MANTOUX intradermal skin test) REQUIRED within 6 months before the start of classes, unless the student has a history of a past positive skin test, which must be indicated and chest x-ray submitted. Tine test is not acceptable.

Date administered \_\_\_\_\_ Date interpreted (within 48-72 hours) \_\_\_\_\_ Induration \_\_\_\_\_ mm  
Month/Day/Year Month/Day/Year

Certifying health professional: \_\_\_\_\_

IF PPD is positive, CHEST X-RAY REQUIRED subsequent to positive PPD result. Attach copy of report. Do not send film

Has student had INH? \_\_\_ No \_\_\_ Yes, date: \_\_\_\_\_

Has student had BCG vaccine? \_\_\_ No \_\_\_ Yes, date: \_\_\_\_\_

IMMUNIZATION RECORD DATES MUST BE WRITTEN MONTH/DAY/YEAR	Date vaccine given (Month/Day/Year)	Initials of certifying health professional	Physician-diagnosed disease history (date of onset)	Serology date/results (copy of lab report MUST be attached)
MEASLES (REQUIRED)	#1 / / #2 / /			
MUMPS (REQUIRED)	/ /			
RUBELLA (REQUIRED)	/ /			
OR Combined as MMR (REQUIRED)	#1 / / #2 / /			
THE FOLLOWING ARE RECOMMENDED BUT NOT REQUIRED FOR ADMISSION. Provide date of most recent tetanus vaccine				
TETANUS/DIPHTHERIA				
VARICELLA				
HEPATITIS B			Or Hepatitis declination --signature below Signature _____ Date ____	
MENINGOCOCCAL			Or refusal of vaccination – signature below Signature _____ Date ____	

I determine that, in my opinion, her/she is free from any physical or mental health impairment which is of potential risk to patient and personnel or might interfere with the performance of his/her duties to include the habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances, which might alter the individuals behavior.

\_\_\_\_\_  
Healthcare Provider's Signature Print Healthcare Provider's Name

Healthcare Provider's Address \_\_\_\_\_ Phone \_\_\_\_\_



**EMS Education  
HEPATITIS B VACCINE DECLINATION FORM**

I, \_\_\_\_\_ have been informed that in order to complete my medical requirements for Emergency Department Clinical Rotations, I must take a series of three (3) Hepatitis -B vaccines under the new OSHA Guideline.

I must arrange for this series of vaccines on my own and through my own clinical practitioner.

I hereby decline to take these vaccines, and do so at my own risk, and release the Course Sponsor, Arnot Ogden Medical Center and its Clinical Hospital Affiliates of all liabilities and personal responsibilities.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature