

MEDICAL EXAMINATION FORM

(INFORMATION CONTAINED HEREIN WILL BE HELD IN CONFIDENCE)

Program: EMT Paramedic

Social Security #: _____ Exam Date: _____

Name: _____ Date of Birth: _____
 [LAST] [FIRST] [MI]

Home Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____ Cell #: _____

All of the following information must be provided and/or completed by a health care provider (MD, DO, ARNP, or PA)

Medical History:

Allergies: _____

Current Medications: _____

Surgeries: _____

Major Illnesses: _____

Back/Orthopedic Problems: _____

History of any communicable or infectious disease(s) which may prevent or hinder this applicant's ability to become a member of the healthcare profession. NO YES (if yes, please explain)

Physical Examination: Height: _____ Weight: _____ Blood Pressure: ____/____
Pulse: _____

Positive Findings: _____

Immunizations:

MMR (date): _____

Tetanus Diphtheria/TD (date): _____ (must be within 10 years)

Hepatitis B Series: #1 _____ (date)

#2 _____ (date)

*Or signature on Hepatitis Declination Statement

#3 _____ (date)

Hepatitis B Titer: _____ (date) Hepatitis B Booster (if required): _____ (date)

Diagnostic Tests:

Date

Results

5 Panel Urine Drug Screen

Rubella Titer (or date
Of last immunization)

Varicella Titer (or date
Of last immunization)

PPD

*Chest X-Ray

*(Chest X-Ray is required as a follow-up for positive PPD results. After chest X-Ray has been completed, the individual must have regular physical examinations to monitor health status.)

Additional Comments/Recommendations: _____

To the best of my knowledge, this individual is in good physical and mental health.

Date: _____

Signature of Health Care Examiner

PRINT name of Health Care Examiner

Address

City/State/Zip

Telephone #

HEALTH CAREER INSTITUTE

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