EMS/Paramedic Program Student Medical Exam Form

Return by designated deadline: Southwestern Illinois College – EMS Program • 2500 Carlyle Ave • Belleville, IL 62221 • Fax: (618) 235-2052

Section 1 – Personal Information

Student completes this section.

Student Name (last, first, middle): _____

Street Address: _____ Phone Number: _____

City, State, Zip: _____ Date of Birth: _____

SWIC Student Email Address: _____ . _____ @student.swic.edu

Emergency Contact:

Name: _____ Relationship: ☐ Spouse ☐ Parent ☐ Other: _____

Phone: _____

Section 2 – Medical History

Student completes this section. Medical examiner is encouraged to discuss with student.

Check all that apply – use the space below to provide details:

- ☐ Heart disease or heart attack
- ☐ Heart murmur or Arrhythmia
- ☐ Fainting/dizziness
- ☐ Diabetes (specify control method)
- ☐ Thyroid disease
- ☐ Eye disorder/vision loss
- ☐ Ear disorder/hearing loss
- ☐ GERD, Chron's disease, IBS, etc
- ☐ Any allergic reaction (drug, food, product, latex, etc)
- ☐ Skin disease
- ☐ Back injury, scoliosis or chronic lower back pain
- ☐ Arthritis
- ☐ Orthopedic disorder
- ☐ Mental disorder/emotional instability
- ☐ Head injury
- ☐ Stroke or paralysis
- ☐ Headaches/migraines
- ☐ Neurological disorder
- ☐ Seizure disorder/Epilepsy
- ☐ Depression
- ☐ Shortness of breath, asthma, cough or hoarseness
- ☐ Pulmonary disease
- ☐ Tuberculosis
- ☐ Cancer (specify type)
- ☐ Abnormal bleeding
- ☐ Major Surgery
- ☐ Other _____
- ☐ Other _____

Provide details from all boxes checked above (attach additional sheets if more room is needed):

_____

_____

_____

_____

List any current medications or treatments (attach additional sheets if more room is needed):

_____

_____

_____

Student: Read, Sign and Date

The information I have provided is complete and accurate to the best of my knowledge and I have attached all laboratory results. I understand that failure to complete this form correctly may jeopardize my participation in the clinical portion of this program.

Signature: _____ Printed Name: _____

Date: _____

Section 3 – Physical Examination

Medical Examiner (MD, DO, ARNP or PA) completes this section.

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____

System:	Normal	Abnormal/Surgery (explain - attach additional sheets if more room is needed)
Cardiovascular	☐	☐ _____
Endocrine/Metabolic	☐	☐ _____
Eyes/Ears/Nose/Throat	☐	☐ _____
Gastrointestinal	☐	☐ _____
Genitourinary	☐	☐ _____
Integumentary	☐	☐ _____
Musculoskeletal	☐	☐ _____
Neurological	☐	☐ _____
Respiratory	☐	☐ _____

Section 4 – Tests/Immunizations – ALL SECTIONS IN WHITE MUST BECOMPLETED

Medical Examiner completes this section.

A **Two Step Tuberculosis Screening:** (Students with proof of annual screenings need Step 1 only.) **Attach chest x-ray if ANY result is positive.**

Step 1 date: ___/___/___ Results: ☐ Neg ☐ Pos | Step 2 date: ___/___/___ Results: ☐ Neg ☐ Pos

Test is required within 1 month of the start of the program.

B **Tdap date:** ___/___/___ **(Tetanus/Diphtheria & Pertussis)**

One time dose of Tdap required. Tdap valid for 10 years.

Td or Tdap booster date: ___/___/___ **(Tetanus/Diphtheria and/or Pertussis)**

Boosters required every two years following initial Tdap 10 year period.

C **Polio Vaccine dates:** 1: ___/___/___ 2: ___/___/___ 3: ___/___/___

OR ☐ Titer *(Attach lab results)* Immune: ☐ Yes ☐ No

D **Measles, Mumps and Rubella:**

MMR Vaccine dose 1: ___/___/___

MMR Vaccine dose 2: ___/___/___

OR

(Attach lab results for all titers)

Measles Titer: ___/___/___ Immune: ☐ Yes ☐ No

Mumps Titer: ___/___/___ Immune: ☐ Yes ☐ No

Rubella Titer: ___/___/___ Immune: ☐ Yes ☐ No

E **Varicella (Chicken Pox):** Indicate disease **or** vaccine **or** titer.

☐ **Disease** was contracted. *(If box checked; MD signature below acts as confirmation.)*

OR ☐ **Vaccine:** Dose 1: ___/___/___ Dose 2: ___/___/___

OR ☐ **Titer**: *(Attach lab results)* Immune: ☐ Yes ☐ No

F **Hepatitis B Vaccine Series:** Student must start the 3 dose process (complete at least one dose) by designated date. Immune:

1: ___/___/___ (Dose 1 started by designated due date of medical exam) 2: ___/___/___ (1 month after dose 1) 3: ___/___/___ (5 months after dose 2)

OR ☐ **Titer**: ☐ Yes ☐ No *(Attach lab results)*

G **Influenza:** When the annual flu vaccine becomes available, it is highly recommended that you receive the vaccine. Those who elect not to get the vaccine may be required to wear a face mask during all Clinicals for student and patient protection.

H COVID-19 Vaccine:	Product Name/Manufacturer:	Date:	
1st Dose		___/___/___	
2nd Dose *(if applicable)*		___/___/___	
Booster		___/___/___	**Attach lab results**

Medical Examiner: Please complete

I verify that I have reviewed this completed form with the student. I consider this student:

☐ Mentally and physically able to undertake this program. ☐ Not mentally and physically able to undertake this program.

Signature:_____ Printed Name: _____ Date:_____

_____/_____/(_____)_____-_____

Office Name/Address/Phone: