


**PHYSICAL EXAMINATION
OF EMS STUDENT**
STUDENT:

Complete page one of this form before the exam. Take completed form to appointment.

Student's name _____

Today's date _____

Date of birth _____

Age at time of exam _____

Gender: Male Female
Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:
 Does the student have any allergies? No Yes (If yes, list specific allergy and reaction.) Medicines Pollens Food Stinging Insects
Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: Has the student...		YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____			
2. Ever stayed more than one night in the hospital?			
3. Ever had surgery?			
4. Ever had a seizure?			
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?			
6. Ever become ill while exercising in the heat?			
7. Had frequent muscle cramps when exercising?			
HEAD/NECK/SPINE: Has the student...		YES	NO
8. Had headaches with exercise?			
9. Ever had a head injury or concussion?			
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?			
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?			
12. Ever been unable to move arms or legs after being hit or falling?			
13. Noticed or been told he/she has a curved spine or scoliosis?			
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?			
15. Been prescribed glasses or contact lenses?			
HEART/LUNGS: Has the student...		YES	NO
16. Ever used an inhaler or taken asthma medicine?			
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____			
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?			
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?			
20. Had discomfort, pain, tightness or chest pressure during exercise?			
21. Felt his/her heart race or skip beats during exercise?			
BONE/JOINT: Has the student...		YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?			
23. Had an injury to a muscle, ligament, or tendon?			
24. Had an injury that required a brace, cast, crutches, or orthotics?			
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?			
26. Had joints that become painful, swollen, feel warm, or look red?			
SKIN: Has the student...		YES	NO
27. Had any rashes, pressure sores, or other skin problems?			
28. Ever had herpes or a MRSA skin infection?			

GENITOURINARY: Has the student...		YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?			
30. Had a history of urinary tract infections or bedwetting?			
31. REMOVED:			
DENTAL:		YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?			
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years			
SOCIAL/LEARNING: Has the student...		YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?			
35. Been bullied or experienced bullying behavior?			
36. Experienced major grief, trauma, or other significant life event?			
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?			
38. Been worried, sad, upset, or angry much of the time?			
39. Shown a general loss of energy, motivation, interest or enthusiasm?			
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?			
41. Used (or currently uses) tobacco, alcohol, or drugs?			
FAMILY HEALTH:		YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other _____			
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____			
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?			
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?			
QUESTIONS OR CONCERNs		YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)			

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between Northern Pennsylvania Regional College and Contracted Clinical Facilities.

Signature of EMS student _____ Date _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes No

	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Print name of examiner _____	
Print examiner's office address _____	Phone _____
Signature of examiner _____	MD <input type="checkbox"/> DO <input type="checkbox"/> PAC <input type="checkbox"/> CRNP <input type="checkbox"/>

HEALTH CARE PROVIDERS: Please photocopy immunization history from student's record – OR – insert information below.

IMMUNIZATION EXEMPTION(S):

Medical Date Issued: _____ Reason: _____ Date Rescinded: _____
Medical Date Issued: _____ Reason: _____ Date Rescinded: _____
Medical Date Issued: _____ Reason: _____ Date Rescinded: _____

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis Type: DTaP, DTP or DT	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Varicella: Vaccine Disease	1	2	3	4	5

ADDITIONAL COMMENTS: