

## EMS Education

### Immunization/Physical Policy 2023

#### Immunizations:

Students are required to have successfully completed immunizations or immunization series, as recommended by the Centers for Disease Control and Prevention, prior to the beginning of the EMS course. Please note, some of these series will require a month or more to complete, so they must be started right away. The following immunizations are required of all students, except in those with documented contraindications (e.g., allergy):

- *Diphtheria, Pertussis and Tetanus (Tdap)*– please note that the pertussis component was not approved for adults until 2005. Also, this immunization is good for a maximum of ten years. If it has been at least ten years since a previous booster (either Tdap or Diphtheria/Tetanus [Td]), a booster must be obtained. If a booster is due, the student must get a Tdap, unless Tdap has previously been administered.
- *Hepatitis B*, recombinant series (note, this consists of three injection series over at least six months). A minimum of two doses must be administered before class begins.
- *Measles* (except in those individuals born before 1957) – Must have two doses after their first birthday. The second dose must have been received after December 31, 1979. A titer is required after for those with a history of measles.
- *Mumps* (except in those individuals born before 1957) – Immunization must have occurred after the student was 12 months old. A titer is required after for those with a history of mumps.
- *Rubella* (except in those individuals born before 1957) – Immunization must have occurred after the student was 15 months of age. A titer is required after for those with a history of rubella.
- *Varicella* (except in those individuals born before 1957) –Must have two doses. A varicella titer is required after for those with a history of chickenpox. If the titer is negative for immunity, the student must receive the immunizations.
- *Influenza*

The following is highly recommended:

- *Polio*

It is necessary for you to obtain information regarding the immunizations you currently have received. The health care provider should record the information on the form approved by EMS Education. The form must be submitted to the Center for Lifelong Learning no later than the Wednesday before the first day of class.

If you are a Cedarville University student and find that you need to update some immunizations, the UMS may be able to provide them, which may result in substantial savings to the student. Also, please

realize that you may be able to get immunizations for little or no cost through your physician (i.e., paid for by your insurance) or possibly health departments where you live.

Students not meeting immunization requirements by the Wednesday before class will be dismissed from the program.

### **Tuberculosis Testing**

Students are required to be tested with a two-step tuberculin skin test (not the Tine test). This requirement may be satisfied by a lab test performed using the BAMT (Blood Assay for Mycobacterium Tuberculosis). Students with a previous positive to either of these tests, including those who have received the BCG vaccine, will be required to have a chest x-ray, as recommended by the Centers for Disease Control and Prevention (<http://www.cdc.gov>). Those with a positive BAMT must also show proof of treatment.

### **Physical Examinations**

All students are required to have a physical examination. EMS Education will provide an EMS Physical form which must be completed by UMS or a Physician and returned to the Center for Lifelong Learning no later than the first day of class.

# EMS EDUCATION - HEALTH HISTORY & PHYSICAL

DATE OF EXAM: \_\_\_\_\_

STUDENT I.D.# \_\_\_\_\_

Name \_\_\_\_\_ Gender \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Home address \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ SS# \_\_\_\_\_

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**In case of emergency, contact:** Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone (h) \_\_\_\_\_ (w) \_\_\_\_\_ Fax# \_\_\_\_\_ E-mail \_\_\_\_\_

**Part I: PERSONAL HEALTH HISTORY**

**EXPLAIN AYES@ ANSWERS BELOW. CIRCLE QUESTION IF YOU ARE UNSURE OF THE ANSWER.**

- |  | YES                      | NO                       |   | YES                      | NO                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Do you have an ongoing or chronic illness?  | <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever become ill from exercising in the heat?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been hospitalized overnight?  | <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you cough, wheeze, or have trouble breathing during or after activity?                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had surgery?   | <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any serious accidents?  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have seasonal allergies that require medical treatment?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you presently under the care of a physician?   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| <p><b><u>List any medications you are currently taking:</u></b></p> <p>_____</p> <p>_____</p>              |                          |                          | <p><b><u>List any allergies: DRUG, FOOD, INSECTS, ENVIRONMENT:</u></b></p> <p>_____</p> <p>_____</p> <p>_____</p> |                          |                          |
| 3. Have you ever passed out?   | <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever had eating disorders/weight problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chest pain during or after exercise?   | <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever had TB or any other communicable disease or exposure?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you get tired more quickly than your friends do during exercise?  | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a positive reading on a tine, PPD, or TB skin test?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had racing of your heart or skipped heartbeats?  | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have arthritis/bone problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had high blood pressure or high cholesterol?  | <input type="checkbox"/> | <input type="checkbox"/> | 11. FEMALES: Do you have menstrual difficulties?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been told you have a heart murmur?   | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you have a history of substance abuse?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Has any family member or relative died of heart problems or of sudden death before age 50?                 | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had emotional/mental health problems?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?   | <input type="checkbox"/> | <input type="checkbox"/> | 14. Any immediate family history of diabetes, heart disease or high blood pressure?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a physician ever denied or restricted your participation in sports for any heart problems?             | <input type="checkbox"/> | <input type="checkbox"/> | 15. Are there any other medical conditions or concerns?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? | <input type="checkbox"/> | <input type="checkbox"/> | If YES, to any questions, please explain here: _____  |                          |                          |
| 5. Have you ever had a head injury or concussion?  | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |
| Have you ever been knocked out, become unconscious, or lost your memory?                                   | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |
| Have you ever had a seizure?   | <input type="checkbox"/> | <input type="checkbox"/> | _____   |                          |                          |
| Do you have frequent or severe headaches?  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

**I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I hereby grant permission for this form to be sent to the Cedarville University EMS Education Department upon completion.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME: \_\_\_\_\_ ID#: \_\_\_\_\_

**PART II: IMMUNIZATION STATUS: (to be completed by Physician or Practitioner)**

Current immunization protection is required for all students. Obtain appropriate immunizations to meet CDC recommendations.

R = required S = suggested		Immunization (Date/s)			Booster (Date)	History of dis.– Requires Titer	Titer Results & Date
Tetanus/Diphtheria/ Pertussis (TDAP) (within 10 yrs)	R						
2 MMR	R	1	2				
Measles (if no MMR)		1	2				
Mumps (if no MMR)		1	2				
Rubella (if no MMR)		1	2				
Hepatitis B (2 shots prior to current term) or waiver	R	1	2	3			
Polio Oral/Salk	S						
2 Varicella (Chickenpox) or titer	R	1	2				
Two step Mantoux (TB)	R	See attached for reporting results					
Influenza (current season)	R						
COVID-19 Immunization	S						

**PART III: PHYSICAL EXAMINATION: (to be completed by Physician or Practitioner)**

Pulse _____	BP _____ / _____	Vision: R 20/ _____ L 20/ _____
Corrected: <input type="checkbox"/> YES <input type="checkbox"/> NO	Pupils: Equal _____ Unequal _____	

	NORMAL	ABNORMAL FINDINGS	INITIALS
<b>MEDICAL</b>			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
<b>MUSCULOSKELETAL/NEUROLOGICAL</b>			
Neck & Back			
Shoulder / Arm / Hand			
Hip / Leg / Ankle			
Foot			
Nervous System			

- Cleared to participate in EMS Program Clinicals
- Cleared after completing : \_\_\_\_\_

**NOT** cleared to participate in EMS Program Clinicals  
Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date: \_\_\_\_\_

Physician (print/type) \_\_\_\_\_