



Student Health History Record

Emergency Medical Services Program

Please Put Your Program Name Here (EMR, EMT, AEMT, or Paramedic)

Please **PRINT** Your Name Here

***Disclaimer:** The health history and physical of any student **IS NOT** used as criteria for acceptance into any Iowa Western Community College Emergency Medical Services Program. The Information contained within this health and immunization record is kept strictly confidential. Once completed, this record will be placed in the student's personal folder.

***Please review this form prior to your appointment with your healthcare provider.**

Iowa Western Community College EMS Education Health History

Student Information

Name: _____ Date of Birth: ____/____/____

Emergency Contact Information

Name: _____ Phone #: _____

Medical History

Prior to your exam, please answer all questions. Comment on all “yes” answers, including year of occurrence.

Have you had / or currently have?	Y	N	Comments
Heart Disease (High Blood Pressure)			
Diabetes			
Respiratory Disorder (Asthma, TB)			
Ear, Nose, Throat Problems			
Psychological or Emotional Disorder			
Convulsive / Seizure Disorder			
Hepatitis, Liver Disease			
Disease or Injury of Joints			
Back Problems OR History of Back Problems			
Has your physical activity every been restricted? (Give reason / duration)			
Do you have any physical limitations that restrict activity and / or require special consideration(s)?			
Have you had any serious illness or injury, or been hospitalized other than already noted?			
Do you have or are you a carrier of any infectious disease which pose a health or safety risk to you or others? (If yes, explain and provide statement from your healthcare provider under which conditions you can't participate)			
Do you have any condition that would restrict activity and / or require special adaptation(s)?			
Are you currently being treated by a healthcare professional for any condition(s)?			
Are you taking any medications regularly or as needed? (Other than Aspirin, Ibuprofen, or Tylenol)			
Allergies / Sensitivities (latex, medications, environmental, food)			

***If there is a change in this information, I will notify my instructor.**

Student Signature: _____ Date: _____

Iowa Western Community College EMS Education Physical Exam

Student Information

Student Name: _____ Program: _____

To be completed by a physician, nurse practitioner, or physician assistant. The physical exam must not be older than one (1) year prior to the start of the program.

Vitals: T: _____ HR: _____ RR: _____ B/P: _____ / _____ HT: _____ / _____ " WT: _____ lbs.

Vision: R 20/ _____ L 20/ _____ **Corrected:** Y _____ N _____

Clinical Evaluation	Within Normal Limits (WNL)	Comments
General Appearance		
HEENT		
Neck / Thyroid (ROM)		
Lungs / Chest		
Cardiovascular		
Abdominal / GU / Hernia		
Back / Spine (ROM, Tenderness)		Lifting Restrictions? Yes _____ or No _____
Psych		
Neurologic		
Other Findings		

If health conditions are present, do they create a limitation in the ability to provide healthcare? Yes _____ or No _____

If Yes; Please Explain _____

Does the student's examination reveal any active illness that would be a hazard to others? Yes _____ or No _____

If Yes; Please Explain _____

Based on today's exam and the disclosed health history, this student does not have any health conditions that would create a hazard to self and others or limit their ability to provide healthcare. In addition, this student is capable of performing the physical requirements of his or her program, which includes but is not limited to bending, stooping, pushing, and lifting without weight restriction.

Agency or Clinic Name	
Printed Name	Title
Signature	Date of Exam

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