

**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 |