

## ATTENTION EMT – BASIC STUDENTS



Please follow these instructions for completing the Health form located in this application packet:

1. Fill in all of the information on page 1. Fill in Medications section.\*
2. On page 2, immunization\* dates are needed for German Measles (Rubella), Tetanus, and Tuberculosis (TB).
  - German Measles (Rubella): documented case (year), immunization after 1969 (list year of immunization): or positive Rubella screen (attach copy of screen).
  - Tetanus: within last ten (10) years (list year of immunization).
  - Tuberculosis (TB): within last five (5) years (list year of immunization or chest x-ray).

\*You have the right to refuse listing any medications or immunizations. To do so, Print REFUSED in the applicable location.

If you need immunizations, they can be obtained either through your clinic or usually through the Public Health office in your county. Please contact your physician with any questions concerning the safety of immunizations for you.

Fill out the Restriction statement; sign at the bottom of page 2.

No physical exam is required for entrance into the EMT-Basic course unless you have restrictions that would require a physician's assessment and permission

You can contact WITC Student Services with any questions pertaining to the enrollment process at 1-800-243-WITC (ask for the WITC campus you are enrolling through). Please complete and return the application form and health form to the appropriate EMS Specialist.

After the application materials and prerequisites are received and found complete, you will be notified with course orientation and course starting date(s) and location(s).

# W.I.T.C. EMT BASIC HEALTH FORM



Semester: Spring \_\_\_ Summer \_\_\_ Fall \_\_\_ Year \_\_\_\_\_ Campus: \_\_\_\_\_

**Applicant Information :**

Last Name	First Name	Middle	/	/	Birthdate
Address			City	State	Zip
			<b>Male Female</b>		
			Gender		
Primary Phone Number	Type	Alt. Phone Number	Type	E-Mail Address	

**Emergency Information**

Last Name	First Name	Relationship	-	-	Phone Number
Address			City	State	Zip

**Medical History:. If you answer yes, please explain**

1. Do you have any medical problems? (Such as asthma, diabetes, high blood pressure, etc.)  Yes  No

---

2. Have you consulted a physician or been hospitalized within the past five years?  Yes  No

---

3. Do you have any restrictions on your physical activities?  Yes  No

---

4. Do you have any allergies to latex or silicone?  Yes  No

---

5. Have you had any previous significant exposure to chemicals, dust, radiation (silica, asbestos, vinyl, chloride, aniline dyes, radiation, other)  Yes  No

---

6. Have you had any surgery(ies), acute or chronic illnesses or significant injuries?  Yes  No

---

7. Do you have any allergies to medications or agents? If yes, list type and reaction:  Yes  No

Please list any medications you use, both prescription and nonprescription, and indicate how often you use them.

Name _____	Frequency _____	Dosage _____
Name _____	Frequency _____	Dosage _____
Name _____	Frequency _____	Dosage _____



Application for admission is considered incomplete until evidence of current immunizations and mantoux or x-ray is provided.

Please circle "Yes," "No," or "Unsure" and fill in the blanks.

	Had Illness	Immunized	Immunization Dates: (Include dates of initial series and booster)
Rubella (German Measles)	Yes No Unsure	Yes No Unsure	
Tetanus	Yes No Unsure	Yes No Unsure	
Tuberculosis	Yes No Unsure	MANTOUX only	Date administered: _____ Type of test: _____ Date _____ Signature: _____ Result: _____
Chest X-ray (If positive PPD) Result			Repeat MANTOUX (if necessary) Date Administered: _____ Type of test: _____ Date Read: _____ Signature: _____ Result: _____

Students may encounter all of the following:

1. Contagious Disease:  
Working with patients who might have an illness that might be contagious to the student; having an illness themselves that may be contagious to the patient or others.
2. Stress:  
Patients or circumstances that may be emotionally stressful to the student, (i.e. child abuse, death, sexual assault).
3. Physical Requirements:  
Lifting patients: pushing/pulling patients, working in enclosed quarters; exposures to adverse weather conditions; working with combative patients

Do you have any lifting restrictions? NO \_\_\_\_\_ YES \_\_\_\_\_ (If yes, you must have a letter from a physician authorizing your safe participation in training. )

If yes, please specify. \_\_\_\_\_

I have read and/or had this form explained to me as needed and understand my rights as related to the information contained in this document.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_