Respond Right EMS Academy
Return To School
Health & Physical Examination

TO THE EXAMINING PHYSICIAN/NP/PA: Please review the student's history and complete this form. This student has been granted provisional acceptance to an EMS training program pending physical exam result. The program will require the student to provide direct patient care. The information contained in this form will be released only with the students' consent.

Last Name **First Name** **Middle**

DOB **Gender**

I. REVIEW OF SYSTEMS

If there are any abnormalities of the following systems, please describe fully, using additional sheets if necessary.

	YES	NO		YES	NO
1. Head, Ears, Nose & Throat			9. Integumentary		
2. Hearing (Any loss or use of aids)			10. Neurological		
3. Vision (Contacts, Glasses, etc.)			11. Psychiatric		
4. Respiratory			12. Endocrine		
5. Cardiovascular			13. Hematologic / Lymphatic		
6. Abdomen / Gastrointestinal			14. Allergic / Immunologic		
7. Genitourinary					
8. Musculoskeletal					

II. HISTORY

MEDICATION:
Is this person currently taking any medication? **Yes** ☐ **No** ☐

If yes, please list the medication or include a printed list.

Medication	Dose

MEDICAL HISTORY:
Does this person have any diagnosed medical, emotional or behavioral conditions? If they are taking a medication as listed above, please list the medical condition they are taking it for. **Yes** ☐ **No** ☐

If yes, please list them or include a printed list.

Medical Condition

ALLERGIES:
Does this person have any food or non-food allergies? **Yes** ☐ **No** ☐

If yes, please list them or include a printed list.

Allergies

Is this person capable of performing the technical standards of an EMT as seen on page 3?

Yes ☐ **No** ☐

If you answered 'No', please explain:

_____

_____

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7491 Mexico Road
St. Peters, MO 63376

Office: 636-387-6200
info@respondright.com

III. Technical Standards

Physical

- Assist in lifting and carrying injured and/or ill people to and from the ambulance.
- Engage in pushing and/or pulling to assist in extrication of a patient pinned beneath or inside a vehicle, and in vehicles with electrical hazards.
- Walk, stand, lift, carry, and balance 125 pounds without assistance, (250 pounds with assistance) while lifting, pulling, pushing and carrying a patient.
- Stoop, kneel, bend, crouch and crawl on uneven terrain to gain access to a patient.
- Climb stairs, hillsides, and ladders to gain access to a patient.
- Work effectively in low light, confined spaces, extreme environmental conditions, and other dangerous environments while remaining calm.
- Perform fine motor movements while in stressful situations and under threatening time constraints.
- Perform major motor movements as required to operate the ambulance stretcher, and equipment.
- Move with sufficient speed to respond to emergency situations

Cognitive

- Locate the scene of an emergency by reading maps and responding safely and quickly to the location as directed by the dispatcher while observing traffic ordinances.
- Perform patient assessments, implement treatment, and calculate weight and volume ratios under threatening time constraints.
- Convey information accurately verbally and written in English
- Evaluate and solve problems
- Prioritize and plan information, tasks and deadlines.

Behavioral (Affective)

- Maintain concentration, be able to adapt to sudden and unexpected changes.
- Respond appropriately to stress and other strong emotions while caring for others.
- Communicate verbally in person, via telephone and radio equipment.
- Work in chaotic environments with loud noises and flashing lights.

Physician/NP/PA Initials ____

IV. IMMUNIZATIONS

MUST provide a printout from your Physician/NP/PA for documentation of immunization records
Documentation of MMR ▪ **(2)** MMR vaccinations at least 1 month apart after age 1; must provide dates for reach ▪ positive titers to measles, mumps and rubella **OR** ▪ documentation of (**2**) measles, (**2**) mumps, and (**1**) rubella vaccination
Documentation of Current Hepatitis A ▪ completion of (**2**) doses;
Documentation of Current Hepatitis B ▪ in progress or completion of all (**3**) doses; must provide dates for each
Documentation of a Negative TB Test (will only accept one of the following): ▪ (**1**) **TB Blood Test** within the **last 12 months** (IGRA) (T-Spot, QuantiFERON Gold, etc.) ▪ Skin Tests will **NOT** be accepted ▪ for a **positive** results only, **must** provide a **Chest X-ray**.
Documentation of Varicella ▪ Series of **(2)** doses; must provide dates for each ▪ immunity by positive titer
Documentation of T-dap. ▪ must be within the last (**10**) years
Documentation of Current Flu Vaccination ▪ required between **Oct 1 and March 31**. These dates are subject to change per CDC guidelines.
Documentation of COVID 19 Vaccine (recommended) ▪ any manufacture of the COVID-19 vaccine will be accepted
Additional immunizations or vaccines could be required per **CDC guidance**

Print Physician/NP/PA Name: _____ **Title:** _____

Signature Physician/NP/PA: _____ **Date:** _____

Practice Name: _____ **Office Phone:** _____

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