PHYSICIAN STATEMENT & RELEASE

Student: _____ EMS Agency: _____

Student DOB: _____ Student Address: _____

Physician's Statement: "I have performed a medical evaluation and reviewed the student's health history. I have the student's Health History & Medical Record on file. I found the above-named student, to the best of my knowledge, to be free from physical or mental impairments including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior altering substances which might interfere with the performance of his/her duties or would impose a potential risk to patients of personnel."

The following immunizations, history or tests have been completed or confirmed: **In Bold = REQUIRED**
Please see the reverse for specific requirements for proof of documentation.

Measles Date: _____/_____ **Mumps** Date: _____/_____

Rubella Date: _____/_____ or ***MMR*** Date:_____/_____

Td/Tdap Date: _____

Varicella Date: _____/_____
(indicate serology results or provider documented disease date) _____

PPD Negative_____ Positive_____ Date: _____
(past positives require screen for signs/symptoms)

Influenza Vaccine Date: _____

Hepatitis B Date: _____ Date: _____ Date: _____

or **Declination Date:* _____

_____ _____
Physician's Name (Please Print) **Physician's Signature**

_____ _____ Physician's Stamp:
Date **Phone #**

_____
Physician's Address

I hereby authorize the above name physician to furnish my Health History and Medical Record to the Department of Health Services, Division of EMS and for the Department of Health Services, Division of EMS to furnish a copy of this Health History & Medical Record to any hospital, or other designated clinical site(s) required by my training as a paramedic in the paramedic program.
Course Sponsor 03-002

_____ _____ _____
Student's Name (Please Print) **Student's Signature** **Date**

Instructions for acceptable proof of immunity- Check one and attach documents

Measles - Mumps - Rubella Immunity (Required):
A certificate of immunization against measles, mumps and rubella which means:
____ Documentation by physician, physician assistant, or nurse practitioner of two doses of MMR.

~~ OR~~

Mumps Immunity (Required):
A certificate of immunization against mumps which means:

___ A document prepared by a physician, physician assistant, nurse practitioner or a laboratory documenting serologic evidence of mumps (a titer) **or**
___ A document indicating one dose of live virus was administered-1st dose on or after 12 months of age, and 2nd dose more than 30 days after first dose, but after age 15 months **or**
___ A copy of a document from previous employer or school which provides the information described above.

Rubella Immunity (Required):
A certificate of immunization against rubella which means:
___ A document prepared by a physician, physician assistant, nurse practitioner or a laboratory documenting serologic evidence of rubella (a titer) **or**
___ A document indicating one dose of live virus was administered on or after the age of twelve months showing date administered **or**
___ A copy of a document from previous employer or school which provides the information described above.

Measles Immunity (Required):
A certificate of immunization against measles for all persons which means:

___ A document prepared by a physician, physician assistant, nurse practitioner or a laboratory demonstrating serologic evidence of measles antibodies (a titer) **or**
___ A document indicating 2 doses of live measles vaccine were administered - 1st dose on or after 12 months of age, and 2nd dose more than 30 days after first dose, but after age 15 months **or**
___ A copy of a document from previous employer or school which provides the information described above.

Varicella Immunity (Required):
____A certificate of immunization against Varicella – two dose series **or**
____ A document prepared by a physician, physician assistant, nurse practitioner or a laboratory documenting serologic evidence of varicella (a titer) **or**
____Physician documented case of Chickenpox, a copy of a document from previous employer or school which provides the information described above.

PPD (Required)
____PPD (TST-Tuberculin Skin Test) - documentation **REQUIRED** prior to shadow/interning experience

Influenza Vaccine (Required)
____Influenza Vaccine, Documented vaccine or mask wear per facility policy

Additional information

____Hepatitis Series – Highly Recommended but not mandatory ____TDaP - Highly Recommended but not mandatory

Student Health History & Medical Record

Name of Student: _____

Age: _____ Date of Birth: _____ Sex: M F

The information contained in this Health History & Medical Record may not be used or disclosed unless specifically authorized by the student or is specifically required or permitted by law.

In order to register for an Original EMS Course requiring a Clinical or Field Rotation, this Health History & Medical Record must be completed and be on file with the student's physician.

Section I – Health History - (To be completed by the student)

DO YOU HAVE or HAVE YOU HAD:	YES	NO		YES	NO
Alcohol/Drug Dependency	( )	( )	Allergies	( )	( )
Asthma/Respiratory Disorders	( )	( )	Diabetes	( )	( )
Difficulty with Coordination	( )	( )	Emotional Disorder	( )	( )
High Blood Pressure	( )	( )	Heart Disease	( )	( )
Joint Disease	( )	( )	Hepatitis	( )	( )
Rheumatic Fever	( )	( )	Kidney Disease	( )	( )
Seizures, Epilepsy or Loss	( )	( )	Bleeding Disorder	( )	( )
Of consciousness			Ulcer	( )	( )
Vision that cannot be	( )	( )	Hernia	( )	( )
Corrected with glasses			Back Disorders	( )	( )
Other _____	( )	( )			

Have you been hospitalized within the past five years?	Yes ( )	No ( )
Do you take any medications on a regular basis?	Yes ( )	No ( )
Have you had the Chickenpox (Varicella)?	Yes ( )	No ( )

To the best of my knowledge, the above statements are true, and I am physically able to meet and perform my duties as outlined in the NYS DOH Job Functionality Policy Statement Policy Statement No. 00-10**. I give permission to my course sponsor to release my medical records to any agency or facility at which I am going to participate in clinical or field time during the course of this program.**

_____ _____ _____

Printed Name of Student Student Signature Date