

# EMT-B Academy Health Assessment

**Print Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

## Health Status: Annual Requirement

- Has there been any changes in your health status; physical or mental over the past year? .....  Yes  No
- Have you had any communicable diseases over the past year? .....  Yes  No
- Have you been hospitalized within the last year? .....  Yes  No
- Are you currently taking any medications? .....  Yes  No
- Do you have any allergies?.....  Yes  No
- Do you have any sensitivity to latex? .....  Yes  No
- Are you currently under any limitations or require modifications to perform your assigned duties? ..  Yes  No

What is the name of your Primary Care Physician? \_\_\_\_\_

If you answer Yes to anything above, please list or describe below:

- Have you had the Hepatitis B series?.....  Yes  No
- Have you had a tetanus shot / Tdap vaccine within the past 10 years? .....  Yes  No

If Yes, What year \_\_\_\_\_

- Do you smoke? .....  Yes  No

## Tuberculosis Screening

- Have you traveled outside the Country in the last 30 days?.....  Yes  No
- Do you have any current or planned immunosuppression? .....  Yes  No
- Have you been in close contact with anyone with tuberculosis? .....  Yes  No

Do you have any of the following lasting 3 weeks or more:

1. An unexplained productive cough? .....  Yes  No
2. Unexpected weight loss? .....  Yes  No
3. Unexplained night sweats? .....  Yes  No
4. Unexplained loss of appetite?.....  Yes  No
5. Unexplained fever? .....  Yes  No
6. Chest pain?.....  Yes  No
7. Unexplained fatigue?.....  Yes  No

It is understood that this form is a confidential document and is released to the hospital for compliance with New York State Public Health Law 405.3 and will be placed in my Employee Health file. I certify that I am presently 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 my duties or would impose a potential risk to patients or personnel. I acknowledge that I have been given the opportunity to receive the Hepatitis B vaccination series.

X \_\_\_\_\_  
**Signature of Student**

**Date:** \_\_\_\_\_

**Please attach a copy of your current immunization record.**