MONTEREY PENINSULA COLLEGE
PUBLIC SAFETY TRAINING CENTER

DATE________________

EMMS 170 A/B
HEALTH SCREENING FORM

NAME____
ADDRESS____
CITY/STATE/ZIP_______________________________________
PHONE__________________SEX____________DATE OF BIRTH___________
NAME OF PARENT OR GUARDIAN______________________________
ADDRESS__________________________________PHONE_______________
CITY/STATE/ZIP_______________________________________
NAME OF FAMILY PHYSICIAN________________________________
ADDRESS__________________________________PHONE_______________
CITY/STATE/ZIP_______________________________________

MEDICAL HISTORY
RECORD OF ILLNESS: CHECK THOSE WHICH YOU HAVE HAD, STAR* IF IT WAS IN THE PAST FIVE YEARS

___ALLERGIES (IF YES, PLEASE SPECIFY)___________________________
___APPENDICITIS
___ASTHMA
___CONVULTIONS
___DIABETES
___EPILEPSY
___HEART DISEASE
___HERNIA
___KIDNEY/BLADDER
___TONSILLITIS
___SURGERY (IF YES, PLEASE SPECIFY)_____________________________

RECORD OF SYMPTOMS: CHECK THOSE WHICH YOU HAVE HAD, STAR*THOSE YOU HAVE NOW

___DIFFICULTY HEARING
___NOSE BLEED
___HEADACHES
___BLACKOUTS
___PAINFUL MENSTRUAL CRAMPS
___SHORTNESS OF BREATH
___CHEST PAINS
___HIGH BLOOD PRESSURE
___FAINTING SPELLS

PLEASE EXPLAIN IN DETAIL

____

____

CHECK IF YOU HAVE EVER INJURED ANY OF THE FOLLOWING:

___FACE OR HEAD
___NECK OR BACK
___CHEST OR ABDOMEN
___SHOULDER
___ARM
___WRIST OR HAND
___LEG
___KNEE
___ANKLE OR FOOT

PLEASE GIVE BRIEF EXPLANATION AND DATE OF ONSET

____

____

DO YOU: (PLEASE CHECK THE FOLLOWING WHICH APPLY)
___WEAR GLASSES
___CONTACT LENSES___HARD___SOFT
___TAKE ANY MEDICATIONS

LIST ALL DRUGS OR MEDICATIONS WITH DAILY OR REGULAR USE

____

____

THE FOLLOWING SHOULD BE COMPLETED BY THE PHYSICIAN
****

______WEIGHT
______HEIGHT
______BLOOD PRESSURE
______PULSE
______RESPIRATORY
______CARDIOVASCULAR
______LEFT VISION ______RIGHT VISION
______EARS
______NOSE
______THROAT
______HERNIA

SHOULDER

______ROM____
______STRENGTH____
______LIGAMENT LAXITY_________________________________

KNEE
______ROM____
______STRENGTH____
______LIGAMENT LAXITY_________________________________

ANKLE
______ROM____
______STRENGTH____
______LIGAMENT LAXITY_________________________________

OTHER
______ROM____
______STRENGTH____
______LIGAMENT LAXITY_________________________________

COMMENTS AND RECOMMENDATIONS:

I HEREBY CERTIFY THAT________________________WAS EXAMINED BY ME ON____________________. AT THAT TIME, NO PHYSICAL CONDITION WAS DETECTED WHICH WOULD REASONABLY BE ANTICIPATED TO RENDER THIS PERSON PHYSICALY UNFIT TO ENGAGE IN THE DUTIES OF AN EMT STUDENT.

SIGNATURE OF EXAMINING PHYSICIAN________________________________