MIAMI DADE COLLEGE MEDICAL CAMPUS
SCHOOL OF HEALTH SCIENCES
EMERGENCY MEDICAL TECHNICIAN PROGRAM

SECTION 1: PERSONAL INFORMATION

_____Apt. _____Address
E-mail address

_____ _____ _____ Gender: M ____F ____
City State Zip Code

_____/ _____/ _____
Date of Birth Last four of SS# Home Telephone Number Cellular Phone Number

_____ _____
Person to Notify in Emergency Relationship Contact Telephone Number

SECTION 2: INFLUENZA INJECTION (Documentation must be attached)

Date of injection: _____Lot _____Expiration Date: _____

I understand that if I cannot participate in the influenza injection process as a result of a medical condition or refuse to participate in the influenza injection, I may be required to participate in additional measures established by a clinical site. Additionally, it may jeopardize my ability to participate in the clinical portion of a Medical Campus program.

STUDENT SIGNATURE: _____ **DATE:** _____

SECTION 3: REQUIRED TITERS/TESTS

Parts A, B, C: THESE BOXES ARE TO BE COMPLETED BY AUTHORIZED MEDICAL PERSONNEL ONLY

A. REQUIRED TITERS: (Documentation must be attached)

A Varicella (Chickenpox), Mumps, Rubeola (Measles), and Rubella (German Measles) Titer must be drawn, and the results attached. ***A record of Vaccines WILL NOT BE ACCEPTED as documentation for the required titers.*** The dates of the titers and the results must be indicated in the appropriate area below. ***(INDICATING THE DISEASE PROCESS OR IMMUNIZATION DATES IS NOT ACCEPTABLE FOR DOCUMENTATION IN THIS AREA).***

TITER	DATE	LAB RESULTS (Documentation must be attached) (Numerical Value of Results Must Be Reported Below)	Please Circle
Varicella (Chickenpox) Titer	_____/____/____ Month Day Year		**Immune/ Not Immune**
Mumps Titer	_____/_____/____ Month Day Year		**Immune/ Not Immune**
Rubeola (Measles) Titer	_____/_____/____ Month Day Year		**Immune/ Not Immune**
Rubella (German Measles) Titer	_____/_____/____ Month Day Year		**Immune/ Not Immune**

B. TB SKIN TEST/ QUANTIFERON /CHEST X-RAY

Two consecutive TB Skin Tests are required. **The TB Skin tests can be repeated at least 7 days but no more than 21 days apart.** The dates and results of each TB Skin Test must be attached. The Skin Tests must have been performed ***within the last three (3) months*** to be considered a recent test. Results from QuantiFERON are acceptable. **In the event the results indicate a positive skin test or**

QuantiFERON, or the student has a history of a positive TB skin test, a chest x-ray is required. The chest x-ray must have been completed within the last three (3) months to be considered current. Results must be attached.

TEST	DATE	RESULTS	
TB Skin Test **1st Test**	____/____/_ **Mo Day Year**	**Positive** _____ **Negative**_____	**If positive skin test, current chest x-ray is required. *Results of TB skin test must be attached.***
TB Skin Test **2nd Test**	____/____/____ **Mo Day Year**	**Positive** _____ **Negative**_____	**If positive skin test, current chest x-ray is required. *Results of TB skin test must be attached.***
QuantiFERON	____/____/____ **Mo Day Year**	**Positive** _____ **Negative**_____	**If positive, current chest x-ray is required. *Results of QuantiFERON must be attached.***
Chest X-ray	____/____/____ **Mo Day Year**	**Positive** _____ **Negative**_____	***RESULTS OF CHEST X-RAY MUST BE ATTACHED***

SECTION 4: HEPATITIS

Introduction: Health care professionals are at risk of exposure to blood and body fluids contaminated with the viruses that cause HIV and Hepatitis. Consistent use of Standard Precautions is the best-known means to avoid transmission of these viruses or other contaminants. Students will be taught Standard Precautions before they provide care to any patient in the clinical setting. Although it is rare, a health care worker may become exposed to one of these viruses through accidental transmission. Currently, there is no vaccine that protects against the HIV virus. However, the Hepatitis B vaccine is an effective means of preventing Hepatitis B. As a student who will be providing direct patient care, you should discuss this vaccine with your health care provider.

About the Vaccine: The Hepatitis B Vaccine is a genetically engineered "yeast" derived vaccine. It is administered in the deltoid muscle (arm) in a series of three doses over a six-month period. You should seek additional information about the vaccine from your health care provider; especially if you have an allergy to yeast or may be pregnant or are a nursing mother.

I have initiated the Hepatitis B Vaccine Series with my first dose listed below: **(ATTACH COPY OF DOCUMENTATION)**

1st Dose: Date: _____/_____/__2nd Dose: _____/__/_____3rd Dose: ____/____/_____
(One month after 1st dose) (Six months after 1st dose)

OR

I have already completed a Hepatitis B Vaccine Program with dates of injections listed below: **(ATTACH COPY OF DOCUMENTATION)**

1st Dose: Date: _____/____/_____2nd Dose: ___/__/_____3rd Dose: ____/____/_____
(One month after 1st dose) (Six months after 1st dose)

OR

Antibody testing has revealed that I have immunity to Hepatitis B. Yes, _____ No _____
(ATTACH COPY OF LAB REPORT).

SECTION 5: Tdap (Tetanus, Diphtheria, Pertussis) Vaccination

Students must provide documentation of the Tdap vaccination within the last ten (10) years.

Received: ____/___/_____**(**ATTACH COPY OF DOCUMENTATION)
Month Day Year

SECTION 6: STUDENT'S STATEMENT

In order to satisfy medical program requirements, I hereby consent to the release and disclosure of my personal health information provided on the **Student Health Record Form** to Miami Dade College and any health care facility in which I am assigned for on-site clinical training. I understand that my personal health information is required to facilitate my participation in the clinical training, which is required for program completion. I also hereby release and hold harmless Miami Dade College and receiving health care facilities from any claim of violation of HIPAA or any other medical privacy rights that may arise for the release of my personal health information provided in the **Student Health Record Form**.

Print Name: _____

Student Signature: _____ Date: _____

PHYSICAL DEMANDS

In order to fulfill the requirements of the EMS Program at Miami Dade College, students must be able to meet the physical demands associated with the profession. Examples of these requirements include but are not limited to the following:

Code: F = frequently O = Occasionally NA = Not Applicable

Physical Demands	Code	Comments
Standing	**F**	
Walking	**F**	
Sitting	**O**	
Lifting (up to 125 pounds)	**F**	
Carrying	**F**	
Pushing	**F**	
Pulling	**F**	
Balancing	**F**	
Climbing	**F**	
Crouching	**F**	
Crawling	**F**	
Stooping	**F**	
Kneeling	**F**	
Reaching	**F**	
Manual Dexterity	**F**	
Feeling	**F**	
Talking	**F**	
Hearing	**F**	
Seeing	**F**	
Communicating	**F**	

(For specific Performance Standards associated with the EMS Program please contact the Program Coordinator at 305-237-4337).

Limitations: _____

_____

SECTION 7: EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this document and that the information about the test results are correct. This individual can participate in all activities required to provide health care to patients in an acute or chronic care facility, emergency setting or any other situation that is part of the learning experiences in the designated health care program. The student is able to meet THE PHYSICAL DEMANDS that are listed above. **(List any limitations associated with this student in the area provided).**

_____ _____

MD/DO/PA/ARNP Signature Date

_____

Office Telephone Number License Number