



GREENFIELD COMMUNITY COLLEGE
Health Services
 One College Drive, Greenfield, Massachusetts 01301
 TEL: (413) 775-1430 FAX: 775-1434



**HEALTH REQUIREMENTS
 Paramedic Students**

Name	_____	_____	_____	_____
	Last	First	Middle	Date of Birth
Address	_____			_____
	Street	Apt.		
	_____	_____	_____	_____
	City	State	Zip Code	Student Number or Social Security Number
Telephone ()	_____			
	Area Code			
Semester entering:	Fall 20 ____	Spring 20 ____		
Have you previously attended GCC?	Yes ____	No ____	If yes, when _____	
Previous Name(s)	_____			

All Paramedic (PMC) students must provide appropriate documentation of immunity as required by the Massachusetts Department of Public Health, Greenfield Community College and clinical sites, **regardless of age or number of credits**. Students must also provide documentation of medical clearance to participate in the PMC program on the Physical Examination form provided.

Students are responsible for providing the Health Service Office with complete health requirement documentation no later than October 1 of the year they enter the PMC program.

Return completed health forms to the Student Health Services Office, Greenfield Community College, North Module, Main Campus or mail to Greenfield Community College Health Services, One College Drive, Greenfield MA 01301-9739. Please call the Health Service Office, (413) 775-1430, to check that forms have been received and that information is complete. If you have any questions concerning the health requirements for the Paramedic Program, please call the Health Services Office.

Prior to application, students are responsible for checking with the Health Services Office for recent changes in health requirements for this program.

Office use only:
__ IZ
__ PPDx2
__ HX
__ PE
PC CONSULT

(Revised March 2009)

SECTION I
IMMUNIZATION INFORMATION

Student Name _____ Date of birth ____/____/____
Last First Middle

A. Tdap (adult tetanus-diphtheria-pertussis) within past 10 years ____/____/____
(one time dose preferred for health care workers if Td > 2 years old)

or
Td (tetanus-diphtheria) within past 2 years ____/____/____

Has primary DPT series been completed? #DTP doses__ Date completed__/____/____

B. 2 Doses of measles, 2 doses of mumps, 1 dose of rubella on or after first birthday, at least one month apart and after 1968,

or
Positive IgG antibody test (s);

MMR ____/____/____ MMR ____/____/____

Measles Vaccine ____/____/____ Mumps Vaccine ____/____/____ Rubella Vaccine ____/____/____
Measles Vaccine ____/____/____ Mumps Vaccine ____/____/____

Positive Measles (Rubeola) IgG antibody ____/____/____ Attach copy of lab report

Positive Mumps IgG antibody ____/____/____ Attach copy of lab report

Positive Rubella IgG antibody ____/____/____ Attach copy of lab report

C. 3 doses of Hepatitis B Vaccine

or
Positive HbsAb

1. Hepatitis B Vaccine ____/____/____

2. Hepatitis B Vaccine ____/____/____

3. Hepatitis B Vaccine ____/____/____

Positive HBsAb ____/____/____ Attach copy of lab report

D. Positive Varicella IgG antibody ____/____/____ Attach copy of lab report
(History or physician diagnosis of disease is not accepted by clinical placements)

If Varicella IgG is negative, then 2 doses of Varicella vaccine, at least 1 month apart, are required:

1. ____/____/____

2. ____/____/____

Signature of Health Care Provider or Designee is Required

Signature _____

Printed Name _____

Address _____

Date _____

Telephone _____

Fax _____

SECTION II



HEALTH HISTORY

(To be filled out by the student)

COMPLETE AND BRING THIS HISTORY FORM WITH YOU TO YOUR PHYSICAL EXAM APPOINTMENT FOR REVIEW WITH THE EXAMINING HEALTH CARE PROVIDER

Please check if you have or have ever had any of the following:

- | | |
|--|---|
| <input type="checkbox"/> chicken pox (date: _____) | <input type="checkbox"/> hernia/rupture |
| <input type="checkbox"/> frequent/severe headaches | <input type="checkbox"/> kidney/bladder problems |
| <input type="checkbox"/> seizure disorder/epilepsy | <input type="checkbox"/> unexplained weight loss/gain |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> swollen glands for longer than 2 weeks |
| <input type="checkbox"/> repeated fainting | <input type="checkbox"/> skin disease/disorder |
| <input type="checkbox"/> problems with vision | <input type="checkbox"/> back injury or problems |
| <input type="checkbox"/> problems with hearing | <input type="checkbox"/> numbness or decreased feeling in hands, feet |
| <input type="checkbox"/> asthma | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> frequent cough | <input type="checkbox"/> diabetes or high blood sugar |
| <input type="checkbox"/> exposure to tuberculosis/positive TB test | <input type="checkbox"/> anxiety/depression |
| <input type="checkbox"/> shortness of breath/difficulty breathing | <input type="checkbox"/> mental illness |
| <input type="checkbox"/> chest pain with activity | <input type="checkbox"/> drug/alcohol dependency |
| <input type="checkbox"/> heart disease/condition/murmur | <input type="checkbox"/> hospitalization |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> surgery |
| <input type="checkbox"/> frequent diarrhea | <input type="checkbox"/> latex allergy _____ |
| <input type="checkbox"/> frequent/severe belly pain | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> cancer | <input type="checkbox"/> other _____ |

limited or painful movement or use of:

- | | | | | |
|---------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> neck | <input type="checkbox"/> shoulder(s) | <input type="checkbox"/> elbow(s) | <input type="checkbox"/> wrist(s) | <input type="checkbox"/> hand(s) |
| <input type="checkbox"/> hip(s) | <input type="checkbox"/> knee(s) | <input type="checkbox"/> ankle(s) | <input type="checkbox"/> feet | <input type="checkbox"/> back |

Please explain any items checked: _____

Please list all medications that you currently take: _____

Please list all allergies (food, medication, latex, environmental):

(Revised March 2009)

Have your activities been restricted during the past 5 years

yes no If yes, please explain: _____

Do you have any condition which might require adaptation of your educational/clinical program?

yes no If yes, please describe: _____

SECTION III

Student statement

- ◆ The health history information given is correct to the best of my knowledge.
- ◆ I agree to notify Health Services Office regarding any significant change in health status.
- ◆ I understand that all health information received by the Health Services Office is confidential and will not be released by the Health Services without my signed consent.
- ◆ I understand that failure to provide complete health requirements by the deadlines will result in the inability to attend classes. I understand that it is my responsibility to provide all the required documentation and to verify the receipt by the Health Services Office of complete documentation.

Student's Signature

Date

SECTION IV

RELEASE of INFORMATION

I, _____ give Greenfield Community College Health Services
Please print name
permission to release information regarding immunizations, immunity to infectious diseases, results of Tuberculosis screening and treatment, latex allergies, and drug sensitivities to the PMC Program Coordinator, and to the clinical agencies (e.g. hospitals, fire departments for my clinical placements).

Student's Signature

Date

I give Health Services permission to release relevant medical history on a need-to-know basis to the PMC Coordinator if necessary to determine ability to safely participate the PMC program.

Student's Signature

Date

(REVISED MARCH 2009)

SECTION V

PHYSICAL EXAMINATION (Bring this form to your Physical Exam)

To be completed and signed by a physician, nurse practitioner or physician's assistant

A. To the Examining Health Care Provider:

- Successful completion of the **Paramedic Program** requires proficiency in the performance of a variety of skills. Technical standards, meant to clarify minimal standards for essential affective and psychomotor functions, require students to:
 - 1) be ambulatory and able to lift, carry and balance up to 100 pounds;
 - 2) be able to bend, stoop, balance and crawl on uneven terrain;
 - 3) have the ability to withstand extreme heat, cold and moisture over extended periods of time;
 - 4) possess fine motor coordination and hand/eye/foot coordination required to perform technical and precise skills;
 - 5) possess visual acuity necessary to perform technical skills and make precise discriminations;
 - 6) have sufficient verbal and auditory perception to be able to perform comprehensive patient assessment, management and transport and to be able to effectively communicate with patients, bystanders and other health professionals;
 - 7) have the emotional stability and maturity to exercise sound judgment while completing patient care activities.
- Please review student history (SECTION II)** for completeness and provide any additional history here: (This information is strictly for use by the Student Health Service Office and will not be released without the student's written consent.)

B. Physical Examination

Date of Physical Examination ___ / ___ / ___

Please complete the physical exam form provided, including a summary of active medical problems and recommendations.

Student Name _____ D/O/B ___ / ___ / ___ Age _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision: Corrected R _____ L _____ Uncorrected R _____ L _____

Hearing: Spoken word _____ Whispered word _____ Tuning fork _____ Audiometry _____
(If available)

	normal	abnormal		normal	abnormal
skin/scars			musculoskeletal:		
HEENT			hands		
neck			wrists		
lymph nodes			elbows		
thorax and lungs			shoulders		
heart			spine		
abdomen			hips		
hernia			knees		
peripheral vascular			ankles		
neurological			feet		
mental status			other:		

Please describe and comment on any abnormal findings:

(Revised March 2000)



C. Summary of Medical/Behavioral Problems and Recommendations:

D. Is this applicant capable of full participation in the Paramedic Program as described by the technical standards in Part V, Section A?

yes _____ no _____

Please describe any accommodations needed to meet the technical standards required for participation in the Paramedic Program:

Are there any further evaluations which should be performed prior to this applicant's participation?

yes _____ no _____

If yes, please explain and give dates for scheduled evaluations:

Results of additional evaluation(s):

____ enclosed

____ to be sent to: Greenfield Community College Health Services
One College Drive
Greenfield MA 01301

E. Signature Required

Signature

____ / ____ / ____
Date

____ / ____ / ____
Date of exam

(must be within one year of start date and updated if any significant change in health since exam)

Name of examining MD, NP or PA (please print)

Address: _____

Telephone: _____

FAX: _____

(Revised March 2009)

SECTION VI Tuberculin Skin Test (PPD/Mantoux)



Student Name: _____ Date of Birth: _____

A Mantoux or PPD after 9/10/09 is required for Fall 2009 entry. Tine tests are not acceptable.

Test should be done before or on the same day as **MMR** or **Varicella** vaccine administration, or no sooner than 4 weeks after these or any live virus vaccines.

PPD

Date planted: ____ / ____ / ____
Date read: ____ / ____ / ____
Result: ____ mm induration
Please do not report as negative or positive

CHEST X-RAY: All positive PPDs require a chest x-ray.

X-ray date: ____ / ____ / ____ Results: _____ **A copy of x-ray report is required.**
 Report attached Report to be sent (other information: _____)

Signature of Health Care Provider or Designee is required

Signature: _____

Date: _____

Printed Name: _____

Address: _____

Telephone: (_____) _____ - _____
