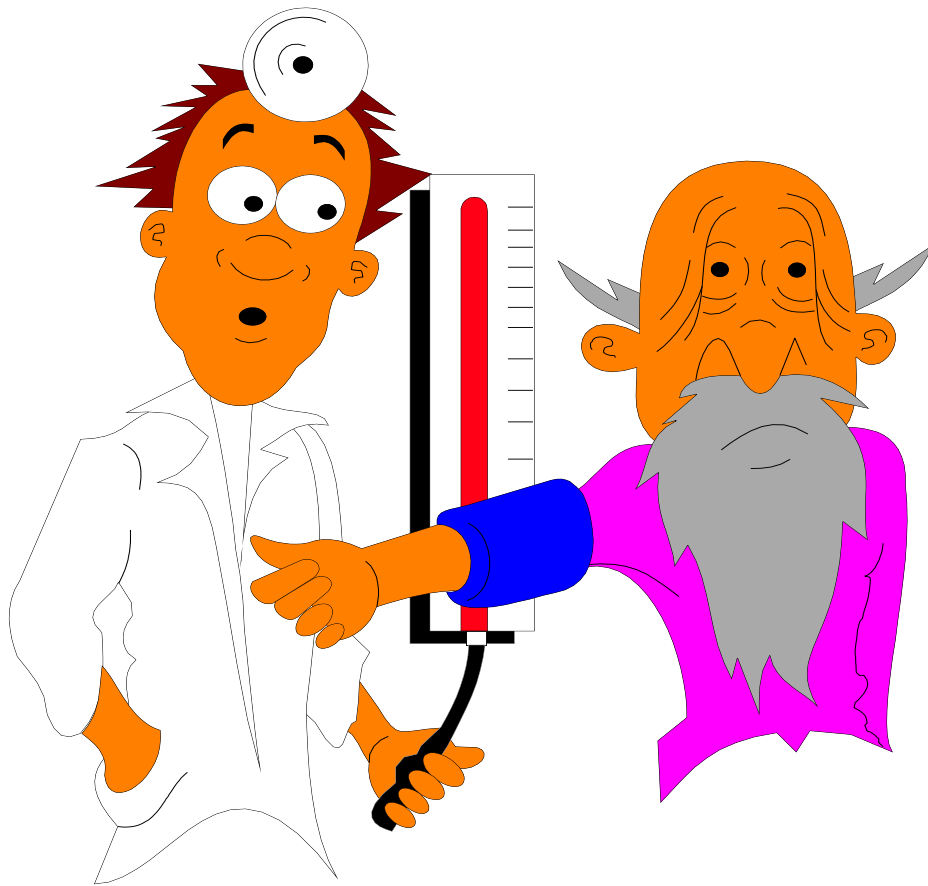


**IMMUNIZATION & PHYSICAL EXAM REQUIREMENTS  
ALS PROVIDERS**



***PLEASE READ IMMEDIATELY***

***PLEASE PRINT INFORMATION LEGIBLY***

Revised July 2018

According to Code 405.3 Title 10 NYCRR, students affiliating with a Health Care Facility must meet certain minimum health requirements. In addition, OSHA requires anyone exposed to blood or body fluids be given education and offer of Hepatitis B vaccine. Therefore, it is **mandatory** that the following form:

IMMUNIZATION RECORD/STUDENT HEALTH HISTORY AND PHYSICAL be completed and sent to the FLREMSC office (Address below). **When a special condition or restriction appears, your record may be subject to review by any REMAC doctor to determine your continuance in the class.**

***\*\*\*Make copies of the records for yourself before you send them\*\*\*.***

**Failure to complete these requirements will result in being denied access to hospital clinical rotation.**

Read the information enclosed **very carefully**. It is **your responsibility** to make sure that **all areas** are completed within the time frame given!!

For records of immunization history:

- Check with personal physician
- Check with High School or college which you last attended
- Check with your "employee health" office where you work

You may have a blood test (titer) done to determine whether or not you have immunity against measles (Rubeola), Mumps, Rubella, Hepatitis B, Meningococcal Meningitis and/or Varicella. **Check with personal physician for this. These blood tests may or may not be covered by your insurance.**

In the event you need the **Measles, Mumps, Rubella, Tetanus Diphtheria, Varicella, Meningitis vaccinations and/or PPD test**, you may:

- Obtain through your personal physician
- Receive them through the Public Health Offices as directed below:
  - **Ontario County** - 585-396-4343 – Call for an appointment.
  - **Seneca County** - 315-539-1800 - **Seneca County Residents only** - Call for an appointment. Clinic (by appointment only) is held once a month.
  - **Yates County** - 315-536-5160 - **Yates County Residents only** - Call for availability. High volumes may not be able to be accommodated.
  - **Wayne County** - 315-946-5749 -.Call for an appointment. **There is a charge for this service. Your Clinical Coordinator has details and rate schedule.**

**Be sure to mention where you volunteer and that you are taking this class when scheduling your appointment. Be sue to ask if there is a cost for each.**

In the event you wish to receive the Hepatitis B vaccine, you may:

- Obtain through your personal physician
- Contact your ambulance corps president and/or your county EMS Coordinator:
  - **Ontario County** Deb Trickey - 585-396-4310
  - **Yates County** Chris Warriner - 315-536-5160
  - **Seneca County** Jeff Case - 315-539-1757
  - **Wayne County** Bill Liddle - 315-946-5640

If you are interested in obtaining the Meningococcal Meningitis vaccine, please call a clinic for an appointment and to determine if the vaccine is available. There will be a charge for this vaccine, please ask the fees when you call. ***Be sure to identify yourself as a FLCC Student when making the appointment.***

Clinic and Location	Phone
Clifton Springs Occupational Medicine Clinic, 2 Coulter Rd., Clifton Springs, NY	315-462-9561
Monroe County Health Department, 111 Westfall Rd., Rochester, NY	585-274-6000
Wayne County Health Department, 1519 Nye Rd., Lyons, NY	1-800-724-1170

Physical examinations may also be arranged with Clifton Springs Occupational Medicine for a nominal fee. ***Be sure to identify yourself as a FLCC Student when making the appointment.*** For details, contact the FLCC Student Health Services at 585-394-3500.

**SEND ALL FORMS TO:  
Clinical Coordinator  
FINGER LAKES REGIONAL EMS COUNCIL INC.  
63 Pulteney Street  
Geneva, NY 14456**

**Or you may fax your forms to the Clinical Coordinator at 315-789-5638**

## COMMON QUESTIONS ABOUT HEALTH REQUIREMENTS:

### 1. WHO HAS TO MEET THESE HEALTH REQUIREMENTS?

- Any and all students who are required to complete clinical observation time within a health care facility.

**\*\*ALL STUDENTS MUST HAVE PROOF OF IMMUNITY TO MEASLES, MUMPS AND RUBELLA REGARDLESS OF THEIR DATE OF BIRTH. STUDENTS BORN PRIOR TO 1957 STILL NEED PROOF OF IMMUNITY TO MUMPS AND RUBELLA. THE ONLY EXCEPTION IS RUBEOLA. THEREFORE, ALL STUDENTS NEED ONE OF THE FOLLOWING:**

1. DATE OF DIAGNOSED DISEASE
  2. PROOF OF TWO VACCINATIONS WITHIN YOUR LIFETIME
- OR
3. BLOOD TEST FOR PROOF OF IMMUNITY

### 2. IF I AM REFRESHING MY EMT, DO I HAVE TO COMPLETE THE HEALTH REQUIREMENTS?

- NO..Unless you will be expected to complete clinical observation time. **Check with your instructor.**

### 3. CAN I REFUSE ANY OF THE HEALTH REQUIREMENTS?

- You may refuse Meningitis and Hepatitis B vaccines. The only way any other vaccine requirement can be waived is if you have a **medical exemption**. This means that your physician must sign a statement, stating the reason that he/she does not want you to get the vaccine.

### 4. WHY DO I HAVE TO DO THIS?

- It is mandated by the **New York State Department of Health** that hospitals be able to prove that **any person** who comes in contact with patients meet these minimum health requirements. **This includes volunteers and students.**

### 5. WHAT IF I DO NOT HAVE OR CAN NOT FIND DOCUMENTATION OF ANY "SHOTS" WHEN I WAS A CHILD?

- You will have to complete the series of immunizations again or ask your doctor to order lab tests to determine immunity for Mumps, Rubeola, Rubella, Hepatitis B, Meningitis and/or Varicella. Your doctor may choose to sign off on the Varicella after asking you a few questions.

### 6. DOES MY BABY BOOK QUALIFY AS DOCUMENTATION?

- NO.. Unless it was signed by your physician at the time of the immunization. You may use it, however, to verify the diagnosis with your current physician, if the doctor will accept it.

## **7. WOULD MY SCHOOL RECORDS COUNT AS DOCUMENTATION?**

- Yes...Obtain a copy and send it with your forms. Please make sure that it is a clear, readable copy.

## **8. WHY DOESN'T A MEASLES VACCINE QUALIFY IF IT WAS GIVEN BEFORE 1968?**

- Prior to 1968, physicians had a choice of either giving a "live" vaccine or a synthetic vaccine. It was determined that the synthetic vaccines were not effective; therefore, unless there is **specific** information that states it was a "live" vaccine, they **are not** counted towards the required two vaccines.

## **9. HOW MUCH TIME BETWEEN EACH MEASLES VACCINE MUST I WAIT, IF I HAVE TO RECEIVE TWO DOSES?**

- The **minimum** time between each dose is **30 days**.

## **10. WHAT IS A PPD?**

- A PPD is a skin test to determine whether or not you have been exposed to tuberculosis. It is administered on the inside of your forearm and **MUST BE READ** between 48 and 72 hours after administration. The reading must be signed and dated by a health practitioner. *Note: If you need to receive both a PPD and an MMR, be sure that the PPD is placed prior to the MMR injection. If MMR is given immediately prior to placement of PPD, the reading is not reliable.*

## **11. IF I HAVE A POSITIVE REACTION TO THE PPD, DOES IT MEAN I HAVE TUBERCULOSIS?**

- NO...It indicates that you might have been exposed to the disease. You will be required to have a chest X-ray.

## **12. DO I HAVE TO GET THE HEPATITIS B VACCINE IN ORDER TO GET INTO THE HOSPITAL?**

- NO...You need only to be educated (as with a film) and may elect to refuse the vaccine. You must sign and date the refusal on your immunization form after the scheduled bloodborne pathogen session.

## **13. IF I REFUSE THE VACCINE, AND CHANGE MY MIND LATER, CAN I STILL GET THE VACCINE?**

- Absolutely. The hospitals need only to know that, at the time of your clinical rotation, you know the risks of contracting hepatitis and are aware that there is a vaccine available. You may change your mind at any time and receive the vaccine.

Students **not** residing in a dormitory do not need to receive the Meningitis vaccine. Please sign and date the refusal form. Students residing in a dormitory should check with their personal physician regarding his/her recommendations.

**ANY FURTHER QUESTIONS, CALL 315-789-0108 or 800-357-3672 IMMEDIATELY**

**REQUIREMENTS FOR IMMUNIZATIONS/PHYSICAL EXAM**

IMMUNIZATION # OF DOSES	REQUIRED FOR WHOM?	NUMBER OF DOSES REQUIRED / TIME FRAME SPECIAL NOTES
<b>MEASLES (RUBEOLA)</b>	Only those students who were born <b><u>on or after</u></b> January 1, 1957	<ul style="list-style-type: none"> <li>• Two (2) doses required.</li> <li>• Vaccines given <u>before</u> 1968 <u>are not acceptable</u> unless specified as “live vaccine.”</li> <li>• First dose on or after 12 months of age.</li> <li>• Second dose on or after 15 months of age.</li> <li>• Minimum of 30 days between the two doses</li> <li>• Verified physician-diagnosed disease is accepted as immunity.</li> <li>• Blood work which shows immunity to disease is also acceptable.</li> </ul>
<b>MUMPS</b>	All students	<ul style="list-style-type: none"> <li>• If born before January 1, 1957, you still need proof of Mumps and Rubella immunity or an MMR booster. <b>Mumps vaccine is not available in any other form.</b></li> </ul>
<b>RUBELLA</b>	All students	<ul style="list-style-type: none"> <li>• One dose of live rubella vaccine on or after 12 months of age.</li> <li>• Blood work which shows immunity to disease is also acceptable.</li> </ul>
<b>TETANUS DIPHTHERIA</b>	All students	<ul style="list-style-type: none"> <li>• Booster must be within past ten years</li> </ul>
<b>TUBERCULOSIS (PPD)</b>	All students	<ul style="list-style-type: none"> <li>• <b>Test within six months of start of class. All CC and Paramedic students must have a yearly PPD in order to continue hospital clinical rotations. You may need to receive another PPD at some point during the class.</b></li> <li>• If positive, must have report of negative chest X-ray and statement by MD indicating ‘no disease.’</li> </ul>
<b>HEPATITIS B</b>	All must be <u>educated</u> about blood borne pathogens & Hepatitis B	<ul style="list-style-type: none"> <li>• This is one of two vaccines that any student can refuse. However, it is highly recommended that all personnel within the health care system take this vaccine.</li> <li>• Series consists of three injections:               <ul style="list-style-type: none"> <li>• 1st (day 0)</li> <li>• 2nd (day 30)</li> <li>• 3rd (day 180)</li> <li>• Blood work which shows immunity to disease is also acceptable.</li> </ul> </li> </ul>
<b>VARICELLA</b>  (CHICKEN POX)	ALL students	<ul style="list-style-type: none"> <li>• Two (2) doses required.</li> <li>• Minimum of 30 days between the two doses.</li> <li>• Verified physician-diagnosed disease is accepted as immunity.</li> <li>• Blood work which shows immunity to disease is also acceptable.</li> </ul>
<b>MENINGOCOCCAL MENINGITIS</b>	All students	<ul style="list-style-type: none"> <li>• This is one of two vaccines that any student can refuse. However, it is highly recommended. Must be within last 10 years.</li> </ul>

<b>Influenza(s)</b>	All Students	<ul style="list-style-type: none"><li>• As mandated for Health Care Workers</li></ul>
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Dear Doctor:

A patient of yours has applied for EMS class(es) with us through the Finger Lakes Community College. He/She must be in reasonably good health and must not have a medical problem that might be aggravated by the physical and emotional stress associated with an emergency situation.

Physically, your patient must be capable of lifting a 125 pound patient onto a gurney with the assistance of one other person. They must also be capable of lifting and carrying approximately 50 pounds of equipment on their own under various types of conditions. These conditions may include but not be limited to climbing stairs, hillsides and walking measurable distances from a roadside or other site.

Emotionally, your patient must be mentally able to handle the emotional and mental strains associated with an ambulance call. Many times when an ambulance is called, the victim is generally critically ill or injured, increasing the potential stress factor to your patient.

Additionally, your patient must not need to take any controlled substances before or during class or clinical rotations that may hamper their abilities.

Your patient has been instructed to complete the medical release on the reverse side of this letter. Please feel free to add any additional comments you feel relevant to your patient's ability to participate in an EMT/AEMT/Paramedic Class (practical applications will be equal to duties that would actually be performed as an EMT/AEMT/Paramedic). Your comments will be kept confidential and kept as a part of the student's file unless a special condition or restriction would require a medical review by any of our REMAC doctors for a determination on the student's participation in the class. Thank you for your time and consideration.

Sincerely,

FLREMSC Training and Education Committee

## STUDENT HEALTH HISTORY AND PHYSICAL

Student's Name: \_\_\_\_\_  
(Printed)

### HISTORY

Medications taken regularly: \_\_\_\_\_

Allergies to medications: \_\_\_\_\_

**Any history of:** (Explain "yes" answers)

	Y/N		Y/N		Y/N
Heart Disease		Hypertension		Seizures	
Impaired Vision		Impaired Hearing		Thyroid Disease	
Liver Disease		Back Problems		Respiratory Disease	

Other Chronic illness: \_\_\_\_\_

### PHYSICAL EXAM

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_

**CHECK IF NORMAL, DESCRIBE IF ABNORMAL:**

	General		Skin
	Ears		Eyes
	Nose/Mouth		Neck/Thyroid
	Heart		Chest/Lungs
	Abdomen		Extremities
	Back		Mental Status
	Neuro		

Comments:

I determine that, in my opinion, he/she is free from any physical or mental health impairment which is of potential risk to patients and personnel or might interfere with the performance of his/her duties to include the habitation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances, which might alter the individual's behavior. I also verify the immunization information (unless individually signed by another health care professional).

\_\_\_\_\_

\_\_\_\_\_

Signature of Health Care Practitioner \_\_\_\_\_

Print name & address of Practitioner \_\_\_\_\_

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

Finger Lakes Regional EMS Council

**IMMUNIZATION RECORD**

NAME :(printed) \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

COURSE NUMBER/INSTRUCTOR \_\_\_\_\_

IMMUNIZATION	DATE	ADMINISTERED/VERIFIED BY:
<b>MMR (MEASLES/MUMPS/RUBELLA) 1ST DOSE</b>		
2ND DOSE		
<b>RUBEOLA (PLAIN MEASLES) 1ST DOSE</b>		
2ND DOSE		
DIAGNOSED DISEASE		
<b>RUBELLA (GERMAN MEASLES) 1 DOSE</b>		
<b>PPD (MANTOUX SKIN TEST) PLANTED</b>		
DATE; READING MM/INDURATION		
<b>HEPATITIS B) 1ST DOSE (DAY 0)</b>		
2ND DOSE (DAY 30)		
3RD DOSE (DAY 180)		
<b>HEPATITIS B REFUSAL</b>		STUDENT SIGNATURE
<b>TETANUS DIPHTHERIA</b>		If vaccine limited by CDC ruling, practitioner please sign and date here _____
<b>VARICELLA (CHICKEN POX) 1<sup>ST</sup> DOSE</b>		
2 <sup>ND</sup> DOSE		
<b>OR</b> DIAGNOSED DISEASE		
<b>MENINGOCOCCAL MENINGITIS</b> Date of Vaccination or student refusal signature		STUDENT SIGNATURE
<b>INFLUENZA(S)</b> As mandated for Health Care Workers 1 2		

**OR LABORATORY TESTS MUST PROVIDE COPY OF LAB REPORT**

TEST	DATE	READING
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MUMPS		
RUBELLA		
RUBEOLA		
HEPATITIS B		
VARICELLA		
MENINGOCOCCAL MENINGITIS		

*ALL IMMUNIZATIONS ADMINISTERED MUST BE SIGNED BY A HEALTH CARE PROVIDER, VERIFYING THE ADMINISTRATION.*

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

**To be completed by student**

Physician's name and address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone Number

\_\_\_\_\_

I authorize the above named physician to furnish and release to Finger Lakes Regional EMS Council any and all information regarding my condition while under your observation or treatment, including the history obtained and physical findings, diagnosis and prognosis. This consent also authorizes the Finger Lakes Regional EMS Council or any REMAC doctor on its behalf to obtain additional information as required or needed should a situation, condition or restriction arise where said council, REMAC doctor or council representative deems it necessary. This release shall be in effect for one year from the date signed.

\_\_\_\_\_  
Student's name (printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Physician's Statement of Fitness**

To be completed by Physician:

The above named patient is now or has previously been in my care. I have reviewed this document and am aware of the physical and emotional stress involved in an EMT/AEMT/Paramedic class. In my professional opinion, the above named patient is capable of participating in this class including its clinical rotations and field time.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Upon request, I authorize Finger Lakes Regional EMS Council to submit an immunization verification form to any hospital and/or clinical site at which I do clinical rotations. This release shall be in effect for one year from the date signed.

\_\_\_\_\_  
Student's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Signature