Cougar ID_____

COLUMBUS STATE COMMUNITY COLLEGE
EMT 1860

HEALTH HISTORY
To be completed by the student:

PLEASE PRINT ALL INFORMATION **COUGAR I.D.**_____

Name:_____ SS#:_____
Last First Middle

Address: _____
Street City State Zip

Date of Birth:_____ Phone: _____
Month/Day/Year Home Other

Program of Study: _____

Semester to Begin Program:_____ E-mail:_____

Answer all questions. If the answer is "no, none, not applicable", write that as your answer. Make certain you have entered your program of study above so we will know which requirements apply to you.

List all allergies and sensitivities you have including medications, food, & environmental:

_____
_____
_____

List all surgical operations you have had with the date:

_____
_____
_____

List all current health conditions you have:

_____
_____
_____

List any previous significant health problems you have had:

_____
_____
_____

_____
Student Signature Date

Covid Card verifying complete series or exemption request must be uploaded in Immuware

Revised 04/06/2023

Cougar ID_____

COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORD

Physical Examination: Must be performed by Physician, Nurse Practitioner or Physician's Assistant

Name:_____ SS#:_____
Last First Middle

Allergies: _____

Medications: _____

Height: _____ Weight: _____ Pulse: _____ B/P:_____

EXAMINER: Indicate your findings after examination of each system

EENT: _____

NEURO: _____

CV: _____

RESP: _____

ENDOCRINE: _____

MUSC/SKEL: _____

- ❑ If this student has any reaction to latex, please complete the Examiner's portion of the "Latex Reactions Form" that the student will supply to you. . **http://cscc.edu/Students/FormsPDF/health/LatexReactionForm.pdf**
- ❑ If this student is subject to any health emergency, please provide special emergency instructions below.
- ❑ If there is additional significant information about this student which would relate to his or her safety for patients or for self in a clinical or laboratory situation, please provide information below.

Does student have any functional limitations or restrictions that would prevent him/her from working in a patient care area?	**Yes**	**No**
Vision, such as reading gauges or monitors?		
Hearing, such as in a classroom or when using a stethoscope?		
Speech, such as in a classroom or while assessing patients?		
Ability to lift and carry up to 50 pounds?		
Walking/Standing/Kneeling on floor/ground for periods of time while performing skills?		
Ability to move an average size adult?		
Sensorimotor (fine and gross)?		
Emotionally stable to deal with stressful situations?		

Does the student have any limitations or restrictions? If no, please document below "No restrictions/No limitations". If **yes**, please provide specific facts regarding student's requirements. _____

Examiner's Signature: _____

Print Examiner's Name: _____

Address: _____

Phone:_____ Date: _____

Name_____ Date of Birth_____ Sex M F

Age_____ Address_____

Emergency Contact: Name_____ Phone Number_____ Relationship_____

The Ohio Department of Public Safety requires Firefighter students to meet the medical requirements of NFPA 1582 Chapter 6 (National Fire Protection Association). Columbus State Community College has adopted these standards for submission by EMT/Paramedic and Firefighter students as a requirement to register for their respective courses.

NFPA 6.1: A medical evaluation of a candidate shall be conducted prior to the candidate being placed in a training program or fire department emergency response activities.

NFPA 6.2.2: Candidates with Category A medical conditions shall not be certified as meeting the medical requirements of this standard.

If a candidate answers YES to any of the *Category A Medical Conditions* (NFPA 3.3.13) listed below, they will not, with only a few exceptions, be permitted to attend firefighter training.

Category A Medical conditions are defined as: *A medical condition that would preclude a person from performing as a member in a training or emergency operation environment by presenting a significant risk to the safety and health of the person or others. Go to:* **https://www.nfpa.org/1582 to view exceptions.**

Student should complete the below health history and present it to their health care professional at time of physical.

For a complete review of the 87-page NFPA 1582 document with listings of exceptions to the guidelines go to: https://www.nfpa.org/1582

6.3 Head and Neck	Yes	No
Do you have any defect of skull preventing helmet use or leaving underlying brain unprotected from trauma?		
Do you have any skull or facial deformity that would not allow for a successful fit of a respirator?		
6.4 Eyes and Vision	Yes	No
Far visual acuity less than 20/40 binocular corrected, or less than 20/100 binocular uncorrected		
Do you have Monochromatic vision?		
Do you have Monocular vision?		
6.5 Ears and Hearing	Yes	No
Do you have chronic vertigo or impaired balance?		
Do you have hearing loss in the unaided better ear greater than 40 decibels(dB) at 500 Hz, 1000 Hz, 2000 Hz, and 3000 Hz when the audiometric device is calibrated to ANSI 224.5?		
Do you require a hearing aid or cochlear implant?		
6.6 Dental	Yes	No
Do you have any dental conditions that result in your inability to use a respirator?		
Do you have any dental conditions that would inhibit your ability to communicate effectively?		
6.7 Nose, Oropharynx, Trachea, Esophagus and Larynx	Yes	No
Do you have a tracheostomy?		
Do you have any nasal, oropharyngeal, tracheal, esophageal, or laryngeal conditions that would inhibit the use of a respirator?		
6.8 Lungs and Chest Wall Do you have any of the following conditions?	Yes	No
Active hemoptysis		
Current empyema		
Pulmonary hypertension		
Active tuberculosis		
Obstructive lung disease		
Lung transplant		
Hypoxemia - Exercise testing is indicated when resting oxygen is less than 94% - Exercise desaturation shall not be less than 90%		
Asthma - reactive airway disease requiring bronchodilator or corticosteroid therapy for 2 or more consecutive months in the previous 2 years, unless the candidate can meet the requirement in 6.8.1.1		

6.9 Aerobic Capacity	Yes	No
Do you have an aerobic capacity less than 12 metabolic equivalents (METs) (12 METs = 42 ml O2/kg/min)?		
6.10.1 Heart Do you have any of the following conditions?	Yes	No
Coronary heart disease		
Cardiomyopathy or congestive heart failure		
Acute pericarditis, endocarditis, or myocarditis		
Recurrent syncope		
Third - degree atrioventricular block		
Cardiac pacemaker		
Hypertrophic cardiomyopathy		
Heart transplant		
A medical condition requiring an automatic implantable cardiac defibrillator		
6.10.2 Vascular System Do you have any of the following conditions?	Yes	No
Hypertension		
Thoracic or abdominal aortic aneurysm		
Carotid artery stenosis or obstruction resulting in greater than or equal to 50% reduction in blood flow		
Peripheral vascular disease		
6.11 Abdominal Organs and Gastrointestinal System	Yes	No
Presence of uncorrected inguinal/femoral hernia		
6.12 Metabolic Syndrome	Yes	No
Metabolic syndrome with aerobic capacity less than 12 METs		
6.13 Reproductive System	Yes	No
Are you pregnant? A "YES" answer does not necessarily indicate non-compliance.		
6.14 Urinary System	Yes	No
Do you have any renal failure or insufficiency requiring continuous ambulatory peritoneal dialysis (CAPD) or hemodialysis?		
- Continued -		

6.15 Spine and Axial Skeleton Do You have any of the following conditions?	Yes	No
Scoliosis of thoracic or lumbar spine with angle greater than or equal to 40 degrees		
History of spinal surgery with rods still in place		
Any spinal or skeletal condition producing sensory or motor deficit or pain due to radiculopathy or nerve root compression		
Any spinal or skeletal condition causing pain that frequently or recurrently requires narcotic analgesic medication		
Cervical vertebral fractures with multiple vertebral body compression greater than 25%		
Thoracic vertebral fractures with vertebral body compression greater than 50%		
Lumbosacral vertebral fractures with vertebral body compression greater than 50%		
6.16 Extremities Do you have any of the following conditions?	Yes	No
Joint replacement		
Amputation or congenital absence of upper extremity		
Amputation of either thumb proximal to the mid-proximal phalanx		
Amputation or congenital absence of lower extremity		
Chronic non-healing or recent bone grafts		
History of more than one dislocation of shoulder without surgical repair or with history of recurrent shoulder disorders within the last 5 years with pain or loss of motion, and with or without radiographic deviations from normal.		
6.17 Neurological Disorders Do you have any of the following conditions?	Yes	No
Ataxias of heredo-degenerative type		
Cerebral arteriosclerosis as evidenced by a history of transient ischemic attack, reversible ischemic neurological deficit, or ischemic stroke		
Hemiparalysis or paralysis of a limb		
Multiple sclerosis with activity or evidence or progression within previous 3 years		
Myasthenia gravis with activity or evidence or progression within previous 3 years		
Progressive muscular dystrophy or atrophy		
Uncorrected cerebral aneurysm		
Any single unprovoked seizures and epileptic conditions, including simple partial, complex partial, generalized, and psychomotor seizure disorders.		
Dementia (Alzheimer's and other neurogenerative diseases) with symptomatic loss of function or cognitive impairment		
Parkinson's disease and other movement disorders resulting in uncontrolled movements, bradykinesia, or cognitive impairment		

Student Name:
Medical Office Name:
Medical Office Phone:
Medical Office Contact Person:

6.18 Skin Do you have any of the following conditions?	Yes	No
Metastatic or locally extensive basal or squamous cell carcinoma or melanoma		
Any dermatologic condition that would not allow for a successful fit test for a respirator		
6.19 Blood and Blood-forming Organs Do you have any of the following conditions?	Yes	No
Hemorrhagic states requiring replacement therapy		
Sickle cell disease (homozygous)		
Clotting disorder		
6.20 Endocrine and Metabolic Disorders Do you have any of the following conditions?	Yes	No
Type 1 Diabetes Mellitus.		
Insulin-requiring type 2 Diabetes Mellitus		
6.22 Tumors and Malignant Diseases Do you have any of the following conditions?	Yes	No
Malignant disease that is newly diagnosed, untreated, or currently being treated, or under active surveillance due to the increased risk of reoccurrence		
6.24 Chemicals, Drugs, and Medications Do you require chronic or frequent treatment with any of the following medications or classes of medications?	Yes	No
Narcotics, including methadone		
Sedative - hypnotics		
Full dose or low dose anticoagulation medications or any drugs that prolong prothrombin time (PT), partial thromboplastin time (PTT), or international normalized ratio (INR)		
Respiratory medications; inhaled bronchodilators, inhaled corticosteroids, systemic corticosteroid, theophylline, and leukotriene receptor antagonists		
High-dose corticosteroids for chronic disease		
Anabolic steroids		
Evidence of illegal drug use detected through testing, conducted in accordance with Substance Abuse and Mental Health Services Administration (SAMHSA)		
Evidence of clinical intoxication or a measured blood level that exceeds the legal definition of intoxication		

This is to certify that the student named herein had a physical exam on _____(date) and is in apparent good health, has no condition that would endanger the health and wellbeing of the students or College staff, has met the requirements of this form, and is physically/mentally able to participate in the EMT/Paramedic and Firefighter program(s) at Columbus State Community College.

Healthcare Provider Printed Name:

Healthcare Provider Signature:

Office Stamp Area:

COLUMBUS STATE COMMUNITY COLLEGE
HEALTH RECORD

Tuberculosis Testing

Name: _____

Tuberculosis Testing

Two-Step Mantoux (intradermal) is required. This involves two Tb Mantoux tests at least 7 days apart and within the last year. Two or three days after each Tb test is given it must be read by the physician, nurse, or physician's assistant. Tb tine tests are not acceptable per state regulations. Two Mantoux tests within the past year can be substituted per state regulations. If the student recently received an MMR or varicella vaccine, the tuberculosis test must be postponed until at least four to six weeks after the MMR.

Tb#1	**Tb#2** At **least 7 days after the first Tb test**:
Date given:_____	Date given:_____
Date read:_____	Date read: _____
Result:_____mm	Result:_____mm
Read by:_____	Read by: _____

If this test or a previous test is positive: Submit documentation of positive PPD and a negative chest x-ray report from within the past five years. If your previous chest x-ray or positive PPD has been more than a year ago, please complete an Annual Health Evaluation form found at https://www.cscc.edu/services/hr_pdf/Annual.pdf

Please note: QFT Gold or T Spot are acceptable in place of a one or two step Tuberculosis skin test and must be current.

Facility Name: _____

Address: _____

Phone:_____ Date: _____

COLUMBUS STATE COMMUNITY COLLEGE
SUPPLEMENTARY IMMUNIZATION RECORD

NAME_____ SS# _____

PROGRAM_____ COUGAR ID#_____

TO BE COMPLETED BY THE PHYSICIAN, NURSE PRACTITIONER, OR PHYSICIAN ASSISTANT

THE FOLLOWING IMMUNIZATIONS ARE *REQUIRED*:

1. **Hepatitis B**: Dates of Hepatitis B immunization: #1_____, #2_____, #3_____(Must have immunization #1 completed before submitting health record and #2 & #3 completed on schedule.)
   OR
   *Date and results of hepatitis B **surface antibody** _____
   NOTE: If the surface antibody is negative, the student must receive the immunization series.

2. **MMR:** Date of first immunization_____Date of second_____
   OR
   *Date and results of Rubeola IGG titer_____, *Mumps IGG titer_____,

   *Date and results of Rubella IGG titer_____.
   NOTE: If titer is negative, the student must receive the immunization series.

   DO NOT RECEIVE MMR IMMUNIZATION WHILE YOU ARE COMPLETING THE TWO-STEP TUBERCULOSIS TEST. The measles component invalidates the tuberculosis test, so you would have to repeat the tuberculosis testing which may delay your ability to register into your program.

3. **Chickenpox/Varicella**: Date of first immunization_____Date of second _____
   Both immunizations required before submitting health record.
   OR
   *Date and results of varicella **IGG** titer _____
   HISTORY OF DISEASE/ILLNESS IS NOT ACCEPTABLE DOCUMENTATION!

   DO NOT RECEIVE THE VARICELLA IMMUNIZATIONS WHILE YOU ARE COMPLETING THE TWO-STEP TUBERCULOSIS TEST.

4. **Tdap**: (Tetanus/Diphtheria/Pertussis) per CDC guidelines _____

5. **Flu Vaccine**:_____**(CURRENT SEASONAL FLU REQUIRED)**

*****Must provide current lab work for series 20 years or older*****

Signature: _____

Printed Name and Title: _____

Organization: _____

Phone: _____ Date: _____

Revised 04/06/2023

INSTRUCTIONS FOR COMPLETION OF HEALTH RECORD and Acknowledgment form

(Digital in Immuware)

1. Please read and follow all instructions so we can process your records as quickly and accurately as possible. If you do not follow instructions or do not submit **complete information**, processing of your health record might be delayed, which might delay your ability to register into your courses. ***All information must be complete before uploading and before you will be eligible to register.***

2. If you are providing photos, please ensure the photos are light and clear; no other objects are to be present in your photo other than your documents.

3. The health history and physical must be on CSCC forms. If you have had a physical examination within the past year, it must be transcribed on CSCC Physical form by the physician, physician assistant, or nurse practitioner.

4. It is **your responsibility**, not your physician's, to make certain that all health requirements have been completed and documentation of all items is submitted to the college. Please verify that you have the appropriate documents prior to submitting them to the college.

5. Records will not be reviewed until all health requirements for your program have been uploaded. Records are processed in the order they are received. Completed health records received by the deadline are processed within 1-5 business days. Completed health records received after the deadline are processed within 5-10 business days from the date of submission

6. **Please ensure you have uploaded all required documentation to Immuware before calling health records to inquire about your submission.**

QUESTIONS?? Call 614-287-2450

The information you are reporting to Columbus State Community College, Office of Student Health Records is used to meet the health requirements determined by the college's clinical affiliates, and to verify your ability to perform essential functions of the clinical tasks safely.

It is the policy of Columbus State Community College not to discriminate against any individual. This assurance of non-discrimination includes applicants for academic admission, and shall be applied regardless of sex, race, color, religion, national origin, ancestry, age, disability, genetic information (GINA), military status, sexual orientation, and gender identity and expression.

I certify that the health information I have given is accurate and complete. I understand that providing false information on this document is a serious offense which will result in disciplinary action. I understand that if my health, physical condition, or physical abilities change during my enrollment in a health-related program at Columbus State Community College I must report these changes to my program coordinator and to the Student Health Records Office. I understand that physical exam and tuberculin testing results may be released to clinical sites prior to my clinical/practicum experiences. I understand that conditions which may affect my ability to perform essential functions of the clinical tasks, or which may affect my ability to function with safety for myself and/or others might be discussed with my department chair or program coordinator.

INSTRUCTIONS FOR SUBMITTING YOUR HEALTH RECORD IN IMMUWARE

1. Request access to Immuware by scanning the QR code below or use the following link https://web.cscc.edu/forms/immuware.php

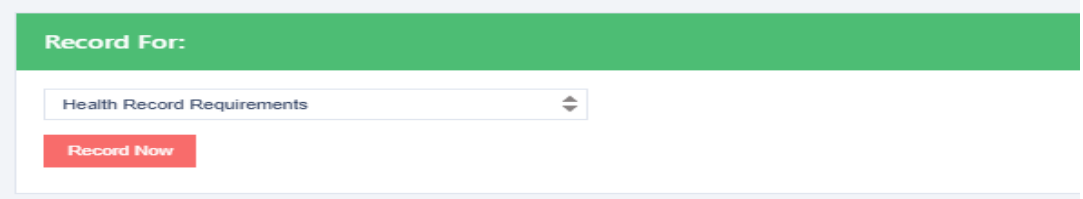
2. A confirmation email regarding your request will be sent to your CSCC student email account

3. You will receive a **Welcome Email** from Immuware when your access to Immuware is ready. Please allow up to 24 hours to receive this email from the time you submit your request

4. Scan the QR code below or use the following link to login to Immuware: https://cscc.immuware.com
   The link in the Welcome Email will be the same

5. You will use your CSCC login and password to login to Immuware

6. You will see the Health Record Requirements under your name, please click the "Record Now" button, select Status Details, choose Student Requirements then select your program of Study (*)



7. Read through all instructions in Immuware to ensure you are submitting your documents properly

8. Please ensure your documents are fully complete before you upload each page and ensure you enter all dates correctly

*** DO NOT SELECT THE RN PROGRAM UNLESS YOU HAVE RECEIVED AN OFFICIAL LETTER OF ACCEPTANCE FROM THE NURSING PROGRAM COORDINATOR. IF YOU SELECT THE RN PROGRAM, PLEASE ALLOW 48 BUSINESS HOURS TO VERIFY YOUR ADMISSIONS INTO THE RN PROGRAM.**