COLUMBUS STATE COMMUNITY COLLEGE
Firefighter

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:____________________________

INSTRUCTIONS FOR COMPLETION OF HEALTH RECORD

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 completed before you will be eligible to register.***

2. 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.
   If you have had a physical examination within the past year you can submit that documentation rather than have another physical at this time IF all of our needed information is on your documentation.

3. 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.

4. **Remember to make photocopies of this record for your own file prior to submitting your documents to the Health Records Office.**

5. **Allow up to five business days to process your health records.** Records are processed in the order in which they are received. If your health records are submitted **less than five business days** prior to the beginning of the registration period, we cannot guarantee that we can process them before the first day of registration.

6. **Submit completed health record to: Columbus State Community College, Health Records Office, Union Hall Room 132, 550 East Spring Street, Columbus OH 43215; or fax to 614-287-5386, including current name and Cougar ID on all faxed pages. You may also email your Health Record to healthrecords@cscc.edu Emails will only be accepted from your student email account (@student.cscc.edu) QUESTIONS?? Call 614-287-2450**

Do you have a sensitivity or allergy to **latex**? No_____ Yes_____

If yes you will need to complete the "Latex Reaction Form" which can be accessed from the college's web site at http://cscc.edu/Students/FormsPDF/health/LatexReactionForm.pdf . Print the form, complete your portion, and then give the form to your physician to complete his or her portion. Your completed Latex Reaction Form must be submitted with the rest of your health record forms.

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

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____
____

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:

____
____
____

The information you are reporting to Columbus State Community College is used to provide health information required 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 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.

_________________________________ _____________________________
Student Signature Date

COLUMBUS STATE COMMUNITY COLLEGE
Firefighter

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 <u>YES</u> 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.**

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

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 theprevious 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 -		

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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** Date given:___________ Date read:___________ Result:_____________ Read by:______________________ **Tb#2** At **least 7 days after the first Tb test**: Date given:_____________ Date read: ______________ Result:________________ 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 http://cscc.edu/Students/FormsPDF/health/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 within the last year.

Facility Name: ____

Address: ____

Phone:________________________ Date: ________________________________

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