

Cougar ID \_\_\_\_\_

**COLUMBUS STATE COMMUNITY COLLEGE**  
***Firefighter***

**HEALTH HISTORY**

**To be completed by the student:**

**PLEASE PRINT ALL INFORMATION**

**COUGAR ID.** \_\_\_\_\_

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:

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List all surgical operations you have had with the date:

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List all current health conditions you have:

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List any previous significant health problems you have had:

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\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
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 NFPA 1580 guidelines with listings of exceptions to the guidelines go to:

<https://www.nfpa.org/1580>

6.3 Head and Neck			Yes	No	6.9 Aerobic Capacity			Yes	No
Do you have any defect of skull preventing helmet use or leaving underlying brain unprotected from trauma?					Do you have an aerobic capacity less than 12 metabolic equivalents (METs) (12 METs = 42 ml O <sub>2</sub> /kg/min)?				
Do you have any skull or facial deformity that would not allow for a successful fit of a respirator?					6.10.1 Heart			Yes	No
6.4 Eyes and Vision			Yes	No	Do you have any of the following conditions?				
Far visual acuity less than 20/40 binocular corrected, or less than 20/100 binocular uncorrected					Coronary heart disease				
Do you have Monochromatic vision?					Cardiomyopathy or congestive heart failure				
Do you have Monocular vision?					Acute pericarditis, endocarditis, or myocarditis				
6.5 Ears and Hearing			Yes	No	Recurrent syncope				
Do you have chronic vertigo or impaired balance?					Third - degree atrioventricular block				
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?					Cardiac pacemaker				
Do you require a hearing aid or cochlear implant?					Hypertrophic cardiomyopathy				
6.6 Dental			Yes	No	Heart transplant				
Do you have any dental conditions that result in your inability to use a respirator?					A medical condition requiring an automatic implantable cardiac defibrillator				
Do you have any dental conditions that would inhibit your ability to communicate effectively?					6.10.2 Vascular System			Yes	No
6.7 Nose, Oropharynx, Trachea, Esophagus and Larynx			Yes	No	Do you have any of the following conditions?				
Do you have a tracheostomy?					Hypertension				
Do you have any nasal, oropharyngeal, tracheal, esophageal, or laryngeal conditions that would inhibit the use of a respirator?					Thoracic or abdominal aortic aneurysm				
6.8 Lungs and Chest Wall			Yes	No	Carotid artery stenosis or obstruction resulting in greater than or equal to 50% reduction in blood flow				
Do you have any of the following conditions?					Peripheral vascular disease				
Active hemoptysis					6.11 Abdominal Organs and Gastrointestinal System			Yes	No
Current empyema					Presence of uncorrected inguinal/femoral hernia				
Pulmonary hypertension					6.12 Metabolic Syndrome			Yes	No
Active tuberculosis					Metabolic syndrome with aerobic capacity less than 12 METs				
Obstructive lung disease					6.13 Reproductive System			Yes	No
Lung transplant					Are you pregnant?				
Hypoxemia - Exercise testing is indicated when resting oxygen is less than 94% - Exercise desaturation shall not be less than 90%					A "YES" answer does not necessarily indicate non-compliance.				
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					6.14 Urinary System			Yes	No
					Do you have any renal failure or insufficiency requiring continuous ambulatory peritoneal dialysis (CAPD) or hemodialysis?				
					- Continued -				

<b>6.15 Spine and Axial Skeleton</b> 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%		
<b>6.16 Extremities</b> 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.		
<b>6.17 Neurological Disorders</b> 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 neurodegenerative 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:

<b>6.18 Skin</b> 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		
<b>6.19 Blood and Blood-forming Organs</b> Do you have any of the following conditions?	Yes	No
Hemorrhagic states requiring replacement therapy		
Sickle cell disease (homozygous)		
Clotting disorder		
<b>6.20 Endocrine and Metabolic Disorders</b> Do you have any of the following conditions?	Do	No
Type 1 Diabetes Mellitus.		
Insulin-requiring type 2 Diabetes Mellitus		
<b>6.22 Tumors and Malignant Diseases</b> 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		
<b>6.24 Chemicals, Drugs, and Medications</b> 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.

Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO):

(PRINT LEGIBLY)

Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) Signature:

# 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: \_\_\_\_\_ mm

Read by: \_\_\_\_\_

**Tb#2 At least 7 days after the first Tb test:**

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

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

Result: \_\_\_\_\_ mm

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.csc.edu/services/hr\\_pdf/Annual.pdf](https://www.csc.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. QFT Gold or T-Spot must be current and lab print out must be uploaded to IMMUWARE.**

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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

# INSTRUCTIONS FOR SUBMITTING HEALTH RECORDS AND UPDATES IN IMMUWARE

1. Already have an Immuware account? Please login to Immuware: <https://cscs.immuware.com> to view your requirements and/or updates
2. Don't have an account yet? Please request access to Immuware by scanning the QR code below or use the following link <https://web.cscs.edu/forms/immuware.php>



3. A confirmation email regarding your request will be sent to your CSCC student email account
4. 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
5. Login to Immuware: <https://cscs.immuware.com>  
The link in the Welcome Email will be the same
6. You will use your CSCC login and password to login to Immuware

You will see all the Health Record Requirements under your name, please click the “Start Here” button, select Status Details, choose Student Requirements then select your program of Study (\*)

A screenshot of the Immuware web interface. At the top is a green header with the text "Start Here" in white. Below the header is a white box containing the text "Select an option from the list below:" followed by a dropdown menu. The dropdown menu currently shows "Health Record Requirements". Below the dropdown is a green button with the text "Start Here" and a small white plus icon.

7. Read through all instructions in Immuware to ensure you are submitting your documents properly; please ensure you are submitting your documents right side up
8. Please ensure your documents are fully complete before you upload each page and ensure you enter all dates correctly
9. You must sign and save the acknowledgment and save All Submissions Complete and Ready for Review as the last step under Submit your Health Record to be placed into Queue for processing

**\* DO NOT SELECT THE RN PROGRAM UNLESS YOU HAVE RECEIVED AN OFFICIAL LETTER OF ACCEPTANCE FROM THE NURSING PROGRAM COORDINATOR**

## **INSTRUCTIONS FOR COMPLETION OF HEALTH RECORD**

1. Please read and follow all instructions on the following pages, so we can process your records quickly and accurately. If you do not follow instructions or submit complete information, processing of your health record may be delayed, which will delay your ability to register into your clinical courses. All information must be complete before uploading into Immuware (Instructions on following 2 pages).
2. If you are providing photos, please ensure the photos are light and clear and display all 4 corners; 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 ensure all health requirements have been completed and documentation of all items uploaded into Immuware.
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 by the first day of registration. Completed health records received after the deadline may take up to 10 business days to process.
6. **All documents must be complete and uploaded to Immuware before saving All submissions complete and ready for review. QUESTIONS?? Call 614-287-2450**

### **Immuware help videos on uploading your health record:**

<https://www.cscce.edu/services/health-records/health-records-videos.shtml>

### **Immuware FAQ and written instructions on how to upload your record:**

<https://www.cscce.edu/services/health-records/pdf/Immuware%20FAQ.pdf>

### **Fact sheet regarding requirements:**

<https://www.cscce.edu/services/pdf/health%20record%20fact%20sheet.pdf>