Yale NewHaven Health
Yale New Haven Hospital

Center for EMS Health Assessment Form

Student information

Name	DOB	☐ Male ☐ Female
Street Address	City/State/Zip	
Phone (Day)	Phone (Evening)	
Phone (Cell)	Other#	
Email address		

Person to Notify in case of Emergency

Name	Relationship
Street Address	City/State/Zip
Phone (Day)	Phone (Evening)
Phone (Cell)	Other #
Email address	

Student Past medical History

Current Medical Problems
Past Medical History
Past Surgical History
Allergies
Medications

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Immunizations: **Titers (from current calendar year) Required for MMR, Varicella and Hep B (or declination)**

MMR Date of Positive Titer Provider Initials	TDAP Date Administered Provider Initials
Varicella Date of Positive Titer Provider Initials	Influenza Date Administered Provider Initials
Hepatitis B Date of Positive Titer Provider Initials	Other

Physical Exam: Check if normal; describe if abnormal

	Check If Normal	Describe Abnormal
HEENT		
Neck		
Lungs		
Heart		
Abdomen		
Lymphatic		
Extremities		
Neurological		
Ortho		
PPD/Date		

SIGNATURES REQUIRED: At the time of this exam, this individual is physically capable of performing the physical duties required of an EMT/Paramedic and is free of any evidence of communicable disease.

Examiner's signature: MD, DO, PA, NP	**Date:**