

Center for EMS Health Assessment Form

Yale New Haven Hospital

Student information Name DOB Male Female City/State/Zip Street Address Phone (Day) Phone (Evening) Phone (Cell) Other# Email address Person to Notify in case of Emergency Relationship Name 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 Required for MMR, Hep B (or declination), Varicella and Proof of Vaccination for TDAP and COVID (with booster)

MMR	Varicella
TDAP	Influenza
Нер В	COVID

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: