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| ***Health History Form for***  ***EMCC Emergency Medical Services Students*** |

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The student’s health care provider must initial individual immunizations AND sign the bottom of the form. ***If a member of the health care provider’s staff fills out this form,******they must initial beside each immunization documented*** **AND** sign the form *in addition* to the health care provider. Official copies of immunization records may be submitted with this form to document certain immunizations. However, this documentation should be reviewed by office staff to be sure it meets our acceptance criteria.

***Instructions***

1. **Rubeola (Measles)**

* Immunization with **2 doses** of vaccine. The doses will be given at different times but must be given later than 1968. *(MMR immunizations are equivalent.)*

**OR**

* Titer **documenting** immunity. (If titer doesn’t show immunity, must have proof of 1 dose of vaccine.)

1. **Mumps**

* Immunization with **2 doses** of vaccine. *(MMR immunizations are equivalent.)*

**OR**

* Titer **documenting** immunity. (If the titer doesn’t show immunity, must have proof of 1 dose of vaccine.)

1. **Rubella (German Measles)**

Only persons born after January 1, 1957, must show proof of either.

* Immunization with 1 dose of vaccine dated later than 1969. *(MMR immunizations are equivalent.)*

**OR**

* Titer **documenting** immunity. (If the titer doesn’t show immunity, must have proof of 1 dose of vaccine.)

1. **Varicella Zoster (Chicken Pox)**

* Immunization with **2 doses** of vaccine.

**OR**

* Titer **documenting** immunity.

1. **Tetanus**

* Immunization within the **last 10** **years.**

1. **Flu Shot**

* Proof of current Flu Season CDC Recommended Flu Shot.

1. **Covid Vaccination**

* Initial **2 dose** vaccination (or J & J one dose option). – Booster not required.

1. **Hepatitis B**

*Note: Basic EMT Students must show that they have at least started the series, ALS students must document completion of the series.*

* If a student ***(both basic and ALS)*** has completed the initial 3 dose series within the last 4-8 calendar weeks, they must have a titer drawn and document immunity. ***Note: this titer is not optional. If the series has been completed within the previous 4-8 weeks, the student must document a titer indicating immunity.***
* If the titer doesn’t show reactive immune, another 3 dose series is required followed by another titer 6 weeks after the completion of the second series.

1. **Tuberculin Test/PPD (test results written in mm rather than negative/positive)**

Persons must show proof of

* Two (2) non-reactive PPD **within the** **past year – completed within thirty days of each other.**

**OR**

* If unable to show proof of PPD’s within the past year, proof of a non-reactive PPD’s and read between 48-72 hours later must be completed.
* Persons known to have had positive reactions in the past will not be skin tested but will show proof of a negative chest x-ray within the past 5 years and complete a Medical TB Surveillance Questionnaire.
* QuantiFERON Gold blood test within the past year.
* Tspot Blood test within the past year.

1. **Healthcare Provider CPR Certification**
2. **FIT Testing**

* 1870 masks (Eastern Maine Medical Center) & 1860 (St. Joseph’s Hospital) mandatory for hospitals in Bangor (Testing available at Eastern Maine Medical Center for a charge.)
* N95 masks

***NOTE:*** *IMMUNIZATIONS SCHEDULED TO EXPIRE BEFORE THE CLASS ENDS WILL NOT BE ACCEPTED!*

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**Student Information**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMCC Student ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_**

**Phone: (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Pager) \_\_\_\_\_**

**Class Taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** *(Basic, AEMT, Paramedic)*

**IMMUNIZATION RECORD**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Immunization** | **Date Given** | **HCP Initials** |  | **Immunization** | **Date Given** | **HCP Initials** |
| **Measles (Rubeola) 1** |  |  |  | **Tetanus** *(Required)* |  |  |
| *(2 doses required)* **2** |  |  |  |  |  |  |
| **Or, Rubeola Titer** |  |  |  | **Hepatitis B 1** |  |  |
| *(Results of Titer)* |  |  |  | **2** |  |  |
|  |  |  |  | **3** |  |  |
| **Mumps 1** |  |  |  | **Or, Hep B Titer** *(Required)* |  |  |
| **2** |  |  |  | *(Results of Titer)* |  |  |
| **Or, Mumps Titer** |  |  |  |  |  |  |
| *(Results of Titer)* |  |  |  | **Varicella (Chicken Pox)** |  |  |
|  |  |  |  | **1** |  |  |
| **Rubella 1** |  |  |  | **2** |  |  |
| **Or, Rubella Titer** |  |  |  | **Or, Varicella Titer** |  |  |
| *(Results of Titer)* |  |  |  | *(Results of Titer)* |  |  |
|  |  |  |  |  |  |  |
| **TB Test Date Given→**  **(PPD two within a  1 month span)**  **Date Read→   OR Date Given→  Date Read→**  **QuantiFERON Gold Blood Test  Tspot Blood Test** | **\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_** |  |  | **Current Year Flu Shot** |  |  |
| *(Results of PPD)* |  |  |  |  |  |  |
| **Or, X-Ray**  **(For those who test positive, documentation of negative chest X-Ray)** |  |  |  | Covid19 Date Given Covid Date Given  Booter Date Given (optional) | \_\_\_\_\_ \_\_\_\_\_ |  |

**I verify that all information recorded on this form is correct to the best of my knowledge:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Signature of Health Care Provider Date Signature of Student Date***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Print name and title of HCP***

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Print name and title of HCP Staff*** *Updated 2/10/23 - HLM*