EMS Education

Immunization/Physical Policy 2019

Immunizations:

Students are required to have successfully completed immunizations or immunization series, as recommended by the Centers for Disease Control and Prevention, prior to the beginning of the EMS course. Please note, some of these series will require a month or more to complete, so they must be started right away. The following immunizations are required of all students, except in those with documented contraindications (e.g., allergy):

- *Diphtheria, Pertussis and Tetanus* (Tdap)– please note that the pertussis component was not approved for adults until 2005. Also, this immunization is good for a maximum of ten years. If it has been at least ten years since a previous booster (either Tdap or Diphtheria/Tetanus [Td]), a booster must be obtained. If a booster is due, the student must get a Tdap, unless Tdap has previously been administered.
- *Hepatitis B*, recombinant series (note, this consists of three injection series over at least six months). A minimum of two doses must be administered before class begins.
- *Measles* (except in those individuals born before 1957) – Must have two doses after their first birthday. The second dose must have been received after December 31, 1979. A titer is required after for those with a history of measles.
- *Mumps* (except in those individuals born before 1957) – Immunization must have occurred after the student was 12 months old. A titer is required after for those with a history of mumps.
- *Rubella* (except in those individuals born before 1957) – Immunization must have occurred after the student was 15 months of age. A titer is required after for those with a history of rubella.
- *Varicella* (except in those individuals born before 1957) –Must have two doses. A varicella titer is required after for those with a history of chickenpox. If the titer is negative for immunity, the student must receive the immunizations.
- *Influenza*

The following is highly recommended:

- *Polio*

It is necessary for you to obtain information regarding the immunizations you currently have received. The health care provider should record the information on the form approved by EMS Education. The form must be submitted to the Center for Lifelong Learning no later than the Wednesday before the first day of class.

If you are a Cedarville University student and find that you need to update some immunizations, the UMS may be able to provide them, which may result in substantial savings to the student. Also, please realize that you may be able to get immunizations for little or no cost through your physician (i.e., paid for by your insurance) or possibly health departments where you live.

Students not meeting immunization requirements by the Wednesday before class will be dismissed from the program.

Tuberculosis Testing

Students are required to be tested with a two-step tuberculin skin test (not the Tine test). This requirement may be satisfied by a lab test performed using the BAMT (Blood Assay for Mycobacterium Tuberculosis). Students with a previous positive to either of these tests, including those who have received the BCG vaccine, will be required to have a chest x-ray, as recommended by the Centers for Disease Control and Prevention (http://www.cdc.gov). Those with a positive BAMT must also show proof of treatment.

Physical Examinations

All students are required to have a physical examination. EMS Education will provide an EMS Physical form which must be completed by UMS or a Physician and returned to the Center for Lifelong Learning no later than the first day of class.

EMS EDUCATION - HEALTH HISTORY & PHYSICAL

DATE OF EXAM: STUDENT I.D.#

Name_____ Gender _____ Date of Birth ____/____/____ Height _____ Weight _____

Home address _____

Home phone _____ Cell phone_____ SS# _____

In case of emergency, contact: Name_____ Relationship_____

Phone (h)_____(w)_____ Fax#_____ E-mail_____

Part I: PERSONAL HEALTH HISTORY

EXPLAIN "YES" ANSWERS BELOW. CIRCLE QUESTION IF YOU ARE UNSURE OF THE ANSWER.

	YES	NO
1. Do you have an ongoing or chronic illness?	❑	❑
2. Have you ever been hospitalized overnight?	❑	❑
Have you ever had surgery?	❑	❑
Have you had any serious accidents?	❑	❑
Are you presently under the care of a physician?	❑	❑
3. Have you ever passed out?	❑	❑
Have you ever had chest pain during or after exercise?	❑	❑
Do you get tired more quickly than your friends do during exercise?	❑	❑
Have you ever had racing of your heart or skipped heartbeats?	❑	❑
Have you had high blood pressure or high cholesterol?	❑	❑
Have you ever been told you have a heart murmur?	❑	❑
Has any family member or relative died of heart problems or of sudden death before age 50?	❑	❑
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	❑	❑
Has a physician ever denied or restricted your participation in sports for any heart problems?	❑	❑
4. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	❑	❑
5. Have you ever had a head injury or concussion?	❑	❑
Have you ever been knocked out, become unconscious, or lost your memory?	❑	❑
Have you ever had a seizure?	❑	❑
Do you have frequent or severe headaches?	❑	❑

List any medications you are currently taking:

_____

_____

	YES	NO
6. Have you ever become ill from exercising in the heat?	❑	❑
7. Do you cough, wheeze, or have trouble breathing during or after activity?	❑	❑
Do you have asthma?	❑	❑
Do you have seasonal allergies that require medical treatment?	❑	❑
8. Have you ever had eating disorders/weight problems?	❑	❑
9. Have you ever had TB or any other communicable disease or exposure?	❑	❑
Have you ever had a positive reading on a tine, PPD, or TB skin test?	❑	❑
10. Do you have arthritis/bone problems?	❑	❑
11. FEMALES: Do you have menstrual difficulties?	❑	❑
12. Do you have a history of substance abuse?	❑	❑
13. Have you ever had emotional/mental health problems?	❑	❑
14. Any immediate family history of diabetes, heart disease or high blood pressure?	❑	❑
15. Are there any other medical conditions or concerns?	❑	❑

List any allergies: DRUG, FOOD, INSECTS, ENVIRONMENT:

_____

_____

_____

If **YES**, to any questions, please explain here: _____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I hereby grant permission for this form to be sent to the Cedarville University EMS Education Department upon completion.

Signature _____ **Date** _____

NAME:_____ ID#:_____

PART II: IMMUNIZATION STATUS: **(to be completed by Physician or Practitioner)**

Current immunization protection is required for all students. Obtain appropriate immunizations to meet CDC recommendations.

R = required S = suggested		**Immunization (Date/s)**			**Booster (Date)**	**History of dis.– Requires Titer**	**Titer Results & Date**
Tetanus/Diphtheria/ Pertussis (TDAP) (within10 yrs)	**R**						
2 MMR	**R**	1	2				
Measles (if no MMR)		1	2				
Mumps (if no MMR)		1	2				
Rubella (if no MMR)		1	2				
HepatitisB (2 shots prior to current term) or waiver	**R**	1	2	3			
Polio Oral/Salk	**S**						
2 Varicella (Chickenpox) or titer	**R**	1	2				
Two step Mantoux (TB)	**R**	See attached for reporting results					
Influenza (current season)	**R**						

PART III: PHYSICAL EXAMINATION**: (to be completed by Physician or Practitioner)**

Pulse _____ BP_____/_____ Vision: R 20/_____ L 20/_____

Corrected: ❍ YES ❍ NO Pupils: Equal _____ Unequal _____

	NORMAL	ABNORMAL FINDINGS	INITIALS
MEDICAL			
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Genitalia (males only)			
Skin			
MUSCULOSKELETAL/NEUROLOGICAL			
Neck & Back			
Shoulder / Arm / Hand			
Hip / Leg / Ankle			
Foot			
Nervous System			

❍ Cleared to participate in EMS Program Clinicals

❍ Cleared after completing :_____

❍ **NOT** cleared to participate in EMS Program Clinicals

Reason:_____

Recommendations: _____

_____ _____

Signature of Physician _____Date:_____

Physician (print/type)_____

Cedarville University EMS Education Tuberculosis Screening

Student Name:_____ DOB:____/____/_____

Students with a history of having had the BCG vaccine should follow the same protocol as outlined below.

Section I

Documentation of regular TST (TB skin test):

- Students must have documentation of a 2 step TST (2 TSTs administered 7 to 21 days apart) to participate in clinical rotations.
- Students can get an annual TST if there is documentation of a 2 step TST **AND** if no more than 12 months have lapsed from the last TST.
- **NOTE: It is the student's responsibility to make sure that their TST does not expire during the academic school year between August 1 and May 1.**

Mantoux 2-step TB testing:

#1 Date given:____/____/_____
Date read: ____/____/_____
Results in mm: _____mm

#2 Date given:____/____/_____
Date read: ____/____/_____
Results in mm: _____mm

Annual Mantoux TB testing:

Date given:____/____/_____
Date read: ____/____/_____
Results in mm: _____mm

Section II

Refer to this section ONLY if student has or ever has had a positive TST or positive BAMT (blood assay for mycobacterium tuberculosis).

1. Students with a positive TST who have a negative BAMT **do not** have to have annual TBT or BAMT but DO have to have annual screening for TB symptoms at UMS.

2. Students with a positive TST and/or a positive BAMT must have annual TB symptom screening at UMS AND:

- Must show documentation of negative BAMT, negative chest x-ray, or prophylactic treatment within the last 6 months.

BAMT test date: ____/____/_____
Results: ____positive
____negative

Chest x-ray date: ____/____/_____
Results: ____positive
____negative

Prophylaxis treatment type and dates:_____
_____
_____

Section III

Refer to this section if student has signs and symptoms of active TB and provide documentation below.

- Proceed with additional testing to exclude active TB disease, including blood assay for mycobacterium TB (BAMT), chest x-ray, and sputum evaluation as indicated.
- Student cannot participate in clinical experience or return to campus until verified to be free from communicability by the UMS physician.

BAMT test date: ____/____/_____
Results: ____positive
____negative

Chest x-ray date: ____/____/_____
Results: ____positive
____negative

Sputum testing date (if indicated): ____/____/____

Results:_____

TB treatment type and dates:_____
_____
_____

Signature of Licensed Health Care Provider:_____ Date:_____

Address:_____Phone:_____