

Fannin County Fire Rescue and EMS



Emergency Medical Services Education Program

Student Health / Physical Form

NAME: _____ PHONE: _____ BIRTH DATE: _____

ADDRESS: _____ CITY/STATE/ZIP CODE: _____

For any box checked in the Health history, please describe condition and treatment (May attach additional pages to explain) List all prescription and over-the-counter medications taken daily: (Include name of med, dose, and frequency).

To be completed by the examiner (Physician, PA, or NP)

Please verify that this student meets the following criteria and is fit for duty by checking the appropriate boxes. (Explain any deficits in the space provided below):

SIGHT: Ability To

- € Discriminate color and differences in color
- € Judge distance between an object and the observer (depth& peripheral perception)
- € See details at near and far distances with corrected vision

HEARING: Ability To

- € Communicate effectively with others orally and in writing
- € Read and understand written information and ideas
- € Listen to and understand information and ideas presented orally
- € Speak clearly so that speech is understandable to listener

COORDINATION/STRENGTH: Ability To

- € Sit, stand and/or walk frequently without limitations
- € Stoop, kneel and reach without limitations
- € Lift up to 50 pounds with frequent lifting and/or carrying objects weighing up to 50 pounds
- € Quickly make coordinated movements of fingers, hands, wrist
- € Keep or regain body balance or stay upright when in an unstable position
- € Coordinate movements of the arms, legs, and torso together when whole body is in motion

REASONING: Ability To

- € Concentrate and not be distracted while performing tasks over a period of time
- € Remember information such as words, numbers, pictures, and procedures
- € Recognize when something is wrong or likely to go wrong
- € Follow directions
- € Add, subtract, multiply or divide quickly and correctly
- € Adjusting actions in relation to actions of others
- € Engage in safe practice without demonstrated behaviors of addiction to, abuse of, or dependence on alcohol or other therapeutic/drugs of abuse

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I have examined this applicant and found him/her to be in good physical condition, free from communicable disease, and apparently physically and mentally fit to perform the duties of the Allied Health Care Provider. Please list any physical disabilities

identified _____

Printed Name of Provider: _____ Date: _____

Address: _____ Phone: _____

Signature of Provider: _____ MD; PA; NP