EMS Programs
RC Health Services

MEDICAL RECORD

This form should be completed by a physician, preferably your family physician. The physician is requested to make a careful examination and give a complete report of the findings.

Name of Applicant____
Last **First** **Middle**

****EVERY BLANK OF THIS HISTORY & PHYSICAL FORM MUST BE FILLED IN****

MEDICAL HISTORY OF APPLICANT

Allergies____
____

Past Medical History____
____

Current Medications____
____

1. Any hoarseness, cough or shortness of breath on moderate exertion?
____

2. Epilepsy, mental disorder, or headache:______________________________

Treatment, if any: ____
____

3. Heart disease:____

4. Childhood diseases (including chicken pox):______________________________
____

5. Surgeries:____

6. Injuries:____

Restrictions as a result of the injury if any:______________________________
____

PHYSICAL EXAMINATION

1. Eyes________________________________ Ears_______________________

Nose________________________________ Throat_____________________

Thyroid_____________________________ Sinuses____________________

2. Heart: Size_______________ Sound______________ Murmurs__________

Rhythm_________ Rate & Rhythm of Pulse___________________________

Blood Pressure____

3. Abdomen: Scars____________________ Tenderness_________________

Palpable masses____

4. Posture_________________ Condition of feet & arches_________________

5. Vision:

Snellin Vision Test ____

Color Acuity Test ____

RECOMMENDATIONS:

1. Do you consider the applicant mentally and physically able to undertake the Emergency Medical Technology program?

____

2. Do you recommend the applicant for admission to the program?

____

3. Are you the family physician? _______How long have you known the applicant?

____

I have on this day given__________________________a careful physical

examination and found the client in___________health.

REMARKS: (General Statement of Physical Condition)____________________

____

Date_____________________ Signature_________________________M.D.

Address______________________________

____

Revised 7/09