Northwest Community Healthcare
Paramedic Program

STUDENT HEALTH RECORD
CONFIDENTIAL

PLEASE PRINT CLEARLY IN BLACK INK ONLY

Name ____ **Birth Date**_____/_____/_____
Last First Middle Initial

☐ **Veteran**

Telephone______________________ ______________________ **Email Address** ______________________
Primary Secondary

Address ____
Street Town State Zip Code

Emergency Contact Relationship (***circle one***) ⟶ Spouse/Guardian/Parent/Other: ______________
Name______________________ Contact Number(s) ______________________

ROUTINE MEDICATIONS: (prescribed and/or over the counter)

____________ ____________ ____________ ____________

MEDICATION ALLERGIES: Yes_____No_____ **FOOD/ENVIRONMENTAL ALLERGIES:** Yes_____No_____

If yes, please list____

FAMILY HISTORY of health problems (heart disease, diabetes, cancer, etc.--include parents, grandparents, siblings, children--be specific):

____

HOSPITALIZATIONS/SURGERIES (type and date) ______________________

____

Social History	No	Yes	If yes, estimate amount/frequency
Tobacco Use			
Exercise			
Alcohol/Drugs			

Have you ever had, or do you now have any of the following:

	No	Yes	Explain answers
Headaches/migraines			
Eye disease			
Ear, nose and throat disease			
Heart problems or high blood pressure			
Breathing problems			
Abdominal pain or liver disease			
Back pain			
Cancer			
Diabetes			
Seizures			
Anxiety/depression/PTSD			
Other mental health/learning concerns			
Tuberculosis			
Rheumatic fever or polio			
Bone or joint problems			
Other diagnosed condition (please list)			

The above information is accurate______________________________ ______________
Signature **Date**

PHYSICAL EXAMINATION – Must be completed by a licensed primary care practitioner

PATIENT NAME ______________________________ **DOB** ______________________________

HEIGHT______________**WEIGHT**______________**BP**______________**PULSE**______________**BMI** ________________

Date of last tetanus vaccination______________________________Td or Tdap? ___________

PHYSICAL ASSESSMENT:

	Within Normal Limits	Abnormal	Explanation of Abnormalities
General survey			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth			
Neck			
Spine & back			
Thorax & lungs			
Breasts			
Heart			
Abdomen			
Extremities			
Musculoskeletal			
Neurological			

RECOMMENDATIONS/COMMENTS____

____

Please check one of the following:

_____ Student MAY participate in the paramedic program without limitations.

_____ Student may participate in physical activity required of a paramedic with the following limitations:

____

_____ Student should NOT participate in any physical activity required of a paramedic.

____ ____________________

Print name / Signature of primary care practitioner **Date**

____

Street address

____

City State Zip Code Telephone