Fire/Rescue Medical Program
Provided by Sound Medical Systems and HealthSure
Islandia • Medford
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Fire / Rescue Medical Program
Evaluation for Medical Certification

Date of Evaluation _____

Name: Mr. Mrs. Ms. First_____ MI_____ Last_____, Jr. Sr.

DOB ____/____/_____ Age_____ M F Fire /Rescue Organization _____

Reason for Evaluation: ❑ Pre-placement / Probationary ❑ Return to Duty ❑ Annual Firefighter Physical

Other_____

Current Function in Fire Department: ❑ Probationary ❑ Indoor Structural ❑ Exterior ❑ Fire Police ❑ EMS

❑ Administrative ❑ Other _____

MEDICAL / SURGICAL / IMMUNIZATION HISTORY

PRIVATE MD:_____ MEDICAL ALLERGIES:_____

Member completed vaccination questionnaire ❑ Yes ❑ No Comment:_____

Member presents with Immunization record ❑ Yes ❑ No Comment:_____

Member attests he/she has received current and up to date vaccination for:

Pneumonia: ❑ No ❑ Yes Date:_____ Hepatitis B: ❑ No ❑ Yes Date:_____

Varicella: ❑ No ❑ Yes Date:_____ Flu (current) ❑ No ❑ Yes Date:_____

Tetanus: ❑ No ❑ Yes Date: _____ MMR: ❑ No ❑ Yes Date:_____

Shingles: ❑ No ❑ Yes Date:_____ Lyme: ❑ No ❑ Yes Date:_____

Member has signed declination form for suggested vaccinations ❑ Yes ❑ No

RECENT HISTORY:	MEDICAL CONDITIONS:	MEDICATIONS:
_____	1._____	1._____
_____	2._____	2._____
_____	3._____	3._____
_____	4._____	4._____
_____	5._____	5._____

Significant family history:_____

First degree Family Member with a history of: Heart attack before age 60 ❑ Yes ❑ No _____

Colon Cancer ❑ Yes ❑ No Breast Cancer ❑ Yes ❑ No Prostate Cancer ❑ Yes ❑ No Other:_____

Smoking History: Current: ❑ Yes ❑ No Prior ❑ Yes ❑ No How many years? _____ Stopped what year?____

Health Maintenance, Date of last evaluation:

Routine Blood work _____ Chest X-Ray_____ GYN Eval _____ Mammography_____

Colonoscopy_____ PSA_____ Stress Test_____ Echo cardiogram_____ CTA of Coronaries_____

Vision; Uncorrected

Distant Right Eye: 20/ Left Eye: 20/ Both: 20/

Near Right Eye: 20/ Left Eye: 20/ Both: 20/

Peripheral Vision:_____

Vision; Corrected; (spectacles or contacts)

Right Eye: 20/ Left Eye: 20/ Both: 20/

Right Eye: 20/ Left Eye: 20/ Both: 20/

Color Vision:_____

Physical Examination:

Blood Pressure _____/_____ Pulse_____ Resp._____ Temp._____ Pulse Ox room air _____%

Height:_____ Ft. _____ In Weight:_____ lbs Waist: _____In. BMI_____

Area examined:	Normal	Abnormal	Comments
Head / Facial Contours			
Eyes			
Ears/Nose/Sinuses			
Mouth /Throat/Airway			
Neck			
Chest and Lungs			
Heart			
Abdomen			
Genitalia			
Prostate			
Skin			
Extremities/hands/feet			
Neurologic			
Emotional Status			

Functional Capacity: ❑ Performed (see attached) ❑ N/A ❑ Back Evaluation (see attached) ❑ N/A

Urinalysis: ❑ Performed (see attached) ❑ N/A PPD placed: ❑ Right ❑ Left Forearm

Member Summary Discussion / Review with Member/Candidate

❑ History / Prior Evaluation Results ❑ EKG ❑ Urinalysis

❑ Exam ❑ Spirometrey ❑ PPD Test Protocol Explained

❑ Health Maintenance ❑ Fit Test ❑ PPD Test return form given to member

❑ Immunization Requirements ❑ Hearing ❑ Other _____

Member displays a potentially disqualifying Category A or B condition according to the NFPA ❑ Yes ❑ No

(Condition that will preclude member from performing the duties for their designated status)

Condition / Issue:_____

According to the examination and the data collected thus far:

❑ This Member is likely to be "Medically Certified" for the requested status in the Fire Department without delay.

❑ This Member is not likely to be "Medically Certified" for the requested status in the Fire Department at this time and an evaluation will have to be reviewed by the Medical Director. Condition / Issue:_____

_____

❑ The above information has been conveyed to the Member ❑ Yes ❑ No Reason_____

❑ This exam has been referred to the Medical Director for review. ❑ Yes ❑ No

❑ Medical Director notified. ❑ Yes ❑ No

Additional Plan / Comments:_____

_____

Physician NP or PA Signature_____ Date:_____