Edison Township EMS-Rescue Squads
New Member Application Supplement
Medical Evaluation Form

Applicant: Complete this section entirely before seeing your healthcare provider. Fill out all items - incomplete items will result in form being returned and application delayed. Complete both sides.

First Name | M I | Last Name | SSN _ _

Address | City | State | Zip

Home Phone | Work Phone | e-mail

Employer | Occupation

Age | Date of Birth | Sex ☐ Male ☐ Female | Height | Weight | Blood Type ☐ A ☐ B ☐ AB ☐ O ☐ pos ☐ neg

Emergency Contact Information

Name | Relationship

Address

Day Phone | Eve Phone

Parental Consent of Medical Care for Members under 18

Parent/Guardian Signature | Date

Relationship

Place a check next to any item you currently have of have a history of:

Medical History

- ☐ Adverse reaction to serum/drug
- ☐ Alcoholism
- ☐ Allergy (food)
- ☐ Allergy (environmental)
- ☐ Anemia
- ☐ Anxiety/Nervousness
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems/Recurrent pain
- ☐ Blood clotts
- ☐ Bone, joint or other deformity
- ☐ Broken Bone
- ☐ Cancer/Tumor/Cyst
- ☐ Chronic or frequent colds
- ☐ Diabetes
- ☐ Digestive disease/disorder
- ☐ Ear Trouble/Hearing Loss
- ☐ Eating Disorder/Anorexia/Bulimia
- ☐ Emotional Distress/Problems
- ☐ Eye Problem
- ☐ Fainting/Syncope
- ☐ Foot problems
- ☐ Frequent indigestion
- ☐ Fungal Disease
- ☐ Gall Bladder Disease
- ☐ Gum/Dental Disease
- ☐ Gynecological Problems
- ☐ Hay Fever
- ☐ Head Injury (unconscious)
- ☐ Heart Problems
- ☐ Hernia
- ☐ High or Low Blood Pressure
- ☐ Insomnia/Trouble Sleeping
- ☐ Intestinal/Stomach Problems
- ☐ Joint Problems (knee, shoulder, elbow)
- ☐ Kidney Disease/Infection/Stones
- ☐ Loss of finger or toe
- ☐ Loss of memory
- ☐ Migraines/Headaches
- ☐ Motion sickness
- ☐ Neuritis
- ☐ Nose/Sinus Problems
- ☐ Pain or pressure in chest
- ☐ Palpitations or pounding heart
- ☐ Persistent Bleeding
- ☐ Recent severe gain or loss of weight
- ☐ Rectal problems/hemorrhoids
- ☐ Rheumatism/Bursitis
- ☐ Seizures/Epilepsy
- ☐ Shortness of Breath
- ☐ Skin Problem
- ☐ Speech Disorder
- ☐ Sugar or albumin in urine
- ☐ Surgery
- ☐ Thyroid Disease
- ☐ Throat/Tonsil Problem
- ☐ Tuberculosis
- ☐ Urinary Tract Infection/Painful urination

Eyes

- ☐ Corrective Glasses
- ☐ Contact Lens
- ☐ Eye Surgery
- ☐ Cataracts
- ☐ Prosthesis

Senses

- ☐ Cochlear Implant
- ☐ Loss of taste/smell
- ☐ Hearing Aid
- ☐ Nerve damage
- ☐ Prosthesis

Infectious Diseases

- ☐ Chicken Pox
- ☐ Hepatitis/Jaundice
- ☐ Herpes
- ☐ Lyme Disease
- ☐ Malaria
- ☐ Measels/Mumps/Rubella
- ☐ Menegitis
- ☐ Mononucleosis
- ☐ Pneumonia
- ☐ Rheumatic Fever/Scarlet Fever
- ☐ Sexually Transmitted Disease
- ☐ Tuberculosis

Describe any items checked above and/or surgeries:

List Any Drug Allergies

The information requested on this form is for the use of Edison Township First Aid Squads and will not be released to anyone without your knowledge and consent except as permitted by law. ©2002 Edison FAS #2, Inc.

Hospitalization & Immunization Record

List any treatments or hospitalizations not previously indicated

Communicable Disease Record

List dates of any immunizations or occurances of disease you have had

Hepatitis B

List dates of inoculation

Step #1 date ____________

Step #2 date ____________

Step #3 date ____________

Tuberculosis

Have you ever had a positive TB Chest X-ray? ☐ Yes ☐ No

Have you ever had a TB exposure? ☐ Yes ☐ No

Date and Result of Mantoux skin test ____________ *pos* *neg*

Tetanus Toxoid

Date of last tetanus inoculation ____________

Varicella (Chicken Pox)

Have you ever had the disease? ☐ Yes ☐ No

Vaccination #1 ____________

Vaccination #2 ____________

Measles Mumps Rubella

MMR Vaccine Date ____________

MMR Titer ____________

Polio

Completed primary polio immunization ☐ Yes ☐ No

Physical Report

(to be completed by certifying physician)

To examining physician: The applicant named on this report has applied for membership with Edison Twp. Volunteer EMS. Because the nature of emergency medical and rescue work requires strenuous physical and mental stability of personnel, all applicants are required to complete a health questionaire and obtain written verification from a physicain certifying his/her health in performing these duties.

Check all of the following systems in which there are abnormalities:

- ☐ Skin
- ☐ Eyes
- ☐ Ears
- ☐ Nose/Sinuses
- ☐ Mouth/Throat/Dental
- ☐ Neck/Thyroid
- ☐ Heart
- ☐ Lungs/Chest
- ☐ Breasts
- ☐ Abdomen
- ☐ Nervous System
- ☐ Extremities/Joints
- ☐ Back
- ☐ Genitourinary System
- ☐ Mental Status

Indicate any of the following conditions

- ☐ Limitations lifting/moving up to 100 lbs.
- ☐ Allergic to latex products
- ☐ Unable to wear a half-piece respirator
- ☐ Wears corrective lens

List any additional findings or comments

Upon examination I find no evidence of injury or illness which would preclude this individual from participating in EMS/Rescue activities or using an OSHA-approved half-face HEPA respirator.

Physician's Signature ____________ Date ____________

Address / City / State ____________

Physician's Printed Name ____________

Telephone Number ____________

For Edison EMS Use Only

Approved for active duty: ☐ Yes ☐ No

Date ____________

Edison EMS Officer Signature ____________