SAN JACINTO COLLEGE
Your Goals. Your College.
E.M.S. EDUCATION

PHYSICAL EVALUTION FORM

STUDENT DEMOGRAPHIC INFORMATION					
NAME	LAST	FIRST	M.I	D.O.B.	
ADDRESS	STREET	CITY	ZIP	GENDER	M F
CONTACT INFORMATION	EMAIL	HOME PHONE	CELL PHONE		
EMERGENCY CONTACT	NAME	HOME PHONE	CELL PHONE		

CHECKLIST EVALUATION FOR EMS FUNCTIONAL JOB DESCRIPTION		
TASK/PHYSICAL DEMAND	YES	NO
Ability to lift, carry and balance up to 125 pounds (250 with assistance)		
Ability to be unaffected by loud noises and flashing lights		
Ability to bend, stoop and crawl on uneven terrain		
Ability to converse, in English, with coworkers and hospital staff with regard to the status of the patient		
Ability to communicate effectively via telephone and radio equipment		
Ability to withstand varied environmental conditions such as extreme heat, cold and moisture		
Ability to work in low light situations and confined spaces		
Ability to read English language manuals and road maps		
Ability to accurately discern street signs and addresses		
Possess good manual dexterity with ability to perform all tasks related to patient care		

MEDICAL HISTORY (IF BOX IS CHECKED, PROVIDE EXPLANATION)		
	CARDIAC DISEASE	
	ENDOCRINE DISEASE	
	GU/GI DISEASE	
	HEMATOLOGIC DISEASE	
	MENTAL ILLNESS	
	NEUROLOGIC DISEASE	
	ORTHOPEDIC INJURIES	
	RENAL DISEASE	
	RESPIRATORY DISEASE	
	OTHER	
	ALLERGIES	
	MEDICATIONS	
	PHYSICAL LIMITATIONS	

NAME	LAST	FIRST	M.I.	D.O.B.	

BLOOD PRESSURE		PULSE		RESPIRATIONS		HEIGHT		WEIGHT	

PHYSICAL ASSESSMENT			
ASSESSMENT	**NORMAL**	**ABNORMAL**	**COMMENTS**
HEAD/EYES/EARS/NOSE/MOUTH/THROAT			
Pupils—equal, reactive, to light			
Eye lids			
Extraocular movements			
Tympanic membrane			
Nasal septum/mucosa			
Teeth/Gums/Tongue/ Pharynx			
NECK			
Range of Motion			
Muscle Strength			
Thyroid			
Carotids			
CHEST/CARDIOVASCULAR			
Inspection			
Auscultation			
Breast (discharge/masses)			
Apical Pulse/Heart Murmurs/Gallops/Size			
ABDOMEN			
Inspection/Auscultation			
Tenderness/Guarding			
Masses/Hernias			
MUSCULAR/SKELETAL/SPINE			
Extremities (edema/Varicosity)			
Range of Motion			
Pulses			
Spinal Alignment/Scoliosis			
GENITALS/RECTAL (MALE)			
Scrotum/Testes (Hernia)			
NERVOUS SYSTEM			
Motor			
Sensory			
Reflexes			
ADDITIONAL ASSESSMENTS/COMMENTS			

NAME	LAST	FIRST	M.I	D.O.B.	

VACCINE	REQUIREMENT	DATE	PROVIDER
MMR	Inoculation 1		
	Inoculation 2		
	OR Titer		
VARICELLA	Inoculation 1		
	Inoculation 2		
	OR Titer		
TDaP	Booster (within 10yrs)		
HEPATITIS B	Inoculation 1		
	Inoculation 2		
	Inoculation 3		
	OR Titer		
HEPATITIS C	Blood Test		
MENINGITIS	Inoculation or N/A		
TB TEST	Skin test (every year)		
	Chest X-Ray (every 5 years)		
FLU VACCINE	08/30—04/01		

I performed the above medical evaluation and found to the best of my knowledge, him/her to be free from physical or mental impairments, including habituation or addiction to depressants, stimulants, narcotics, alcohol or other behavior-altering substances which might interfere with the performance of his/her duties or would pose a potential risk to patients or personnel.

◯ YES

◯ NO, If checked, please document those problems which might interfere with the performance of his/her duties or may cause a potential risk to patients, personnel or self.

PHYSICIAN PRINTED NAME (or STAMP)

PHYSICIAN SIGNATURE

PRACTICE PHONE NUMBER

DATE OF EXAM