MPC | PUBLIC SAFETY TRAINING CENTER
MONTEREY PENINSULA COLLEGE

DATE_____

EMMS 170 A/B
HEALTH SCREENING FORM

NAME_____
ADDRESS_____
CITY/STATE/ZIP_____
PHONE_____SEX_____DATE OF BIRTH_____
NAME OF PARENT OR GUARDIAN_____
ADDRESS_____PHONE_____
CITY/STATE/ZIP_____
NAME OF FAMILY PHYSICIAN_____
ADDRESS_____PHONE_____
CITY/STATE/ZIP_____

MEDICAL HISTORY
RECORD OF ILLNESS: CHECK THOSE WHICH YOU HAVE HAD, STAR* IF IT WAS IN THE PAST FIVE YEARS

___ALLERGIES (IF YES, PLEASE SPECIFY)_____
___APPENDICITIS
___ASTHMA
___CONVULTIONS
___DIABETES
___EPILEPSY
___HEART DISEASE
___HERNIA
___KIDNEY/BLADDER
___TONSILLITIS
___SURGERY (IF YES, PLEASE SPECIFY)_____

RECORD OF SYMPTOMS: CHECK THOSE WHICH YOU HAVE HAD, STAR*THOSE YOU HAVE NOW

___DIFFICULTY HEARING
___NOSE BLEED
___HEADACHES
___BLACKOUTS
___PAINFUL MENSTRUAL CRAMPS
___SHORTNESS OF BREATH
___CHEST PAINS
___HIGH BLOOD PRESSURE
___FAINTING SPELLS

PLEASE EXPLAIN IN DETAIL

_____

_____

CHECK IF YOU HAVE EVER INJURED ANY OF THE FOLLOWING:

___FACE OR HEAD
___NECK OR BACK
___CHEST OR ABDOMEN
___SHOULDER
___ARM
___WRIST OR HAND
___LEG
___KNEE
___ANKLE OR FOOT

PLEASE GIVE BRIEF EXPLANATION AND DATE OF ONSET

_____

_____

DO YOU: (PLEASE CHECK THE FOLLOWING WHICH APPLY)
___WEAR GLASSES
___CONTACT LENSES___HARD___SOFT
___TAKE ANY MEDICATIONS

LIST ALL DRUGS OR MEDICATIONS WITH DAILY OR REGULAR USE

_____

_____

THE FOLLOWING SHOULD BE COMPLETED BY THE PHYSICIAN
****
_____WEIGHT
_____HEIGHT
_____BLOOD PRESSURE
_____PULSE
_____RESPIRATORY
_____CARDIOVASCULAR
_____LEFT VISION _____RIGHT VISION
_____EARS
_____NOSE
_____THROAT
_____HERNIA

SHOULDER

_____ROM_____
_____STRENGTH_____
_____LIGAMENT LAXITY_____

KNEE
_____ROM_____
_____STRENGTH_____
_____LIGAMENT LAXITY_____

ANKLE
_____ROM_____
_____STRENGTH_____
_____LIGAMENT LAXITY_____

OTHER
_____ROM_____
_____STRENGTH_____
_____LIGAMENT LAXITY_____

COMMENTS AND RECOMMENDATIONS:

I HEREBY CERTIFY THAT_____WAS EXAMINED BY ME ON_____. AT THAT TIME, NO PHYSICAL CONDITION WAS DETECTED WHICH WOULD REASONABLY BE ANTICIPATED TO RENDER THIS PERSON PHYSICALY UNFIT TO ENGAGE IN THE DUTIES OF AN EMT STUDENT.

SIGNATURE OF EXAMINING PHYSICIAN_____

PHYSICIAN'S STAMP OR CLINIC INFORMATION BELOW

_____

MPC | PUBLIC SAFETY TRAINING CENTER
MONTEREY PENINSULA COLLEGE

DATE 7/29/23

EMMS 170 A/B
HEALTH SCREENING FORM

NAME Jane Doe
ADDRESS 123 Main Street
CITY/STATE/ZIP Monterey, CA 93940
PHONE (831) 555-1212 SEX F DATE OF BIRTH 1/1/2000
NAME OF PARENT OR GUARDIAN or emergency contact
ADDRESS 123 Main Street PHONE (831) 464-0020
CITY/STATE/ZIP Monterey, CA 93940
NAME OF FAMILY PHYSICIAN or provider of physical John Smith
ADDRESS 1513 Fremont Blvd PHONE (831) 899-1910
CITY/STATE/ZIP Seaside, CA 93955

MEDICAL HISTORY
RECORD OF ILLNESS: CHECK THOSE WHICH YOU HAVE HAD, STAR* IF IT WAS IN THE PAST FIVE YEARS

* ALLERGIES (IF YES, PLEASE SPECIFY) Soy
N/A APPENDICITIS
N/A ASTHMA
N/A CONVULTIONS
N/A DIABETES
N/A EPILEPSY
N/A HEART DISEASE
N/A HERNIA
N/A KIDNEY/BLADDER
N/A TONSILLITIS
N/A SURGERY (IF YES, PLEASE SPECIFY)

RECORD OF SYMPTOMS: CHECK THOSE WHICH YOU HAVE HAD, STAR*THOSE YOU HAVE NOW

N/A DIFFICULTY HEARING
N/A NOSE BLEED
N/A HEADACHES
N/A BLACKOUTS
N/A PAINFUL MENSTRUAL CRAMPS
N/A SHORTNESS OF BREATH
N/A CHEST PAINS
N/A HIGH BLOOD PRESSURE
FAINTING SPELLS

PLEASE EXPLAIN IN DETAIL

N/A

CHECK IF YOU HAVE EVER INJURED ANY OF THE FOLLOWING:

N/A FACE OR HEAD
N/A NECK OR BACK
N/A CHEST OR ABDOMEN
N/A SHOULDER
N/A ARM
N/A WRIST OR HAND
N/A LEG
N/A KNEE
N/A ANKLE OR FOOT

PLEASE GIVE BRIEF EXPLANATION AND DATE OF ONSET

N/A

DO YOU: (PLEASE CHECK THE FOLLOWING WHICH APPLY)

N/A WEAR GLASSES
N/A CONTACT LENSES ___ HARD ___ SOFT
✓ TAKE ANY MEDICATIONS

LIST ALL DRUGS OR MEDICATIONS WITH DAILY OR REGULAR USE

Loratadine 10mg - for seasonal allergies.

THE FOLLOWING SHOULD BE COMPLETED BY THE PHYSICIAN

****

125lbs WEIGHT
5'8 HEIGHT
134/72 BLOOD PRESSURE
56 PULSE
✓ RESPIRATORY
___ CARDIOVASCULAR
___ LEFT VISION -0.25 RIGHT VISION +0.25
___ EARS
___ NOSE
___ THROAT
✓ HERNIA

SHOULDER

✓ ROM Full
↓ STRENGTH
↓ LIGAMENT LAXITY

KNEE
✓ ROM Full
↓ STRENGTH
↓ LIGAMENT LAXITY

ANKLE
✓ ROM Full
↓ STRENGTH
↓ LIGAMENT LAXITY

OTHER
N/A ROM
↓ STRENGTH
↓ LIGAMENT LAXITY

COMMENTS AND RECOMMENDATIONS:

I HEREBY CERTIFY THAT John Doe WAS EXAMINED BY ME ON 7/23/2023. AT THAT TIME, NO PHYSICAL CONDITION WAS DETECTED WHICH WOULD REASONABLY BE ANTICIPATED TO RENDER THIS PERSON PHYSICALLY UNFIT TO ENGAGE IN THE DUTIES OF AN EMT STUDENT.

SIGNATURE OF EXAMINING PHYSICIAN John Smith

PHYSICIAN'S STAMP OR CLINIC INFORMATION BELOW

Doctors On Duty
1513 Fremont Blvd, Ste B
Seaside, CA 93955
Phone 831-899-1910
Fax 831-393-9481