Fire Medic Student Health Form & Medical Clearance Instructions

LTC is required to provide proof to our clinical agencies that our students entering their facilities will not be exposing their clients to any illness or disease. Students are required to complete the following requirements before clinical placement will be made.

Proof of vaccinations may be either a provider signature on the health form or a copy of the record.
Check the Wisconsin Immunization Registry for your vaccine history.
Vaccines, TB skin testing, pulmonary function testing and medical clearance can be obtained from the occupational health departments at your local clinic or hospital. Students can access the LTC College Nurse for TB testing. Blood tests are obtained from any provider that can perform laboratory testing.

The following numbered items provide detailed instructions for the corresponding numbers on the health form.

1. Proof of chickenpox is completed by **either** turning in a blood test (titer) result **or** showing proof of two vaccines in your lifetime. History of having the disease as a child is not proof.

2. Proof of having a Tdap booster (Tetanus, diphtheria, and pertussis booster) in the last 10 years.

3. Proof of having 2 MMR (Measles, Mumps, Rubella) vaccinations in the past OR turning in 3 blood test (titer) results, one each for Measles, Mumps and Rubella.

4. Proof of having a TB test within the last year. Options include a two-step Tuberculin (TB) skin test (skin test given and read within 72 hours), TB Gold blood test, or T-spot test in the last year. **The College nurse is able to do the TB skin test by appointment on the Cleveland campus at no cost to students over the age of 18.** If you have tested positive in the past, you need to submit a copy of the positive skin test, chest x-ray report, any treatment received, and complete a previous positive form (available from the college nurse).

5. Proof of having completed the series of three Hepatitis B vaccines or sign the declination statement on the second page of the form.

6. Proof of a current season flu shot if you are in a clinical setting between November 1 and March 31, or a signed waiver available from the college nurse. However, if you are applying in late spring and summer, flu shots are not available. In that case, you will need to get the shot as soon as it becomes available in fall.

7. You need to obtain medical clearance within the last year to participate in the program. Medical clearance consists of **two parts**; a **pulmonary function test** and **medically fit to participate statement** by the occupational physician completing your paperwork.

8. You need to sign the health form.

Students are responsible for any costs for the above services.

If questions on these instructions please contact:

Lakeshore Technical College
Renee Bruckschen, College Health Nurse
1290 North Ave
Cleveland WI 53015-1414
E-mail: Renee.bruckschen@gotoltc.edu
Fax: 920.693.3561
Phone: 920.693.1111

Fire Medic Student Health Form & Medical Clearance

Name:_____ Student ID Number:_____

Telephone Number: _____Birth Date:_____

1. **Proof of Chickenpox:** Varicella Titer date & Results_____ **OR** Dates of Vaccine #1 _____#2_____(attach copy)

2. **Diphtheria/Tetanus Date:** _____(Tdap____) (**required** within 10 years of program entry)

3. **Proof of (2) MMR's or Rubeola, Mumps, and Rubella titers.**

1)MMR_____ _____
Date Authorized Signature & Title OR a copy of the records

2)MMR_____ _____
Date Authorized Signature & Title OR a copy of the records

OR

Rubeola titer_____ _____ _____
Date Results Authorized Signature & Title OR a copy of the records

Mumps titer_____ _____
Date Results Authorized Signature & Title OR a copy of the records

Rubella titer_____ _____ _____
Date Results Authorized Signature & Title OR a copy of the records

4. **2 Step Mantoux Tuberculin Skin Test, T-spot test** OR TB Gold test within the last year. (Attach copy)

DATE GIVEN:_____ _____
Authorized Signature & Title OR a copy of the records

DATE READ:_____ _____
Authorized Signature & Title OR a copy of the records

_____**NEGATIVE** _____**POSITIVE** _____**MM INDURATION**

Chest x-ray needed only when TB Skin Test is POS or HISTORY of POS reaction. Please attach CXR &/or treatment reports.

5. **HEPATITIS B VACCINATION**

The Hepatitis B vaccine is not a requirement, but is recommended to protect the student from potential risks.

____NO, I am declining the vaccination. **I am required to sign the declination below.**

____YES, I have completed the vaccine (list below).

1st_____ _____
Date Authorized Signature & Title OR a copy of the records

2nd_____ _____
Date Authorized Signature & Title OR a copy of the records

3rd_____ _____
Date Authorized Signature & Title OR a copy of the records

HEPATITIS B VACCINATION DECLINATION **Fill out this section only if you <u>choose NOT to receive the Hepatitis B vaccination</u> at this time.** Lakeshore Technical College & faculty recommend that you be immunized for Hepatitis B to protect you from potential risks. I have read the information about Hepatitis B and the Hepatitis B vaccine. I understand that I may be at risk of acquiring Hepatitis B virus infection; however, **I choose to decline the Hepatitis B vaccination <u>at this time</u>.** I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I will assume full liability as a result of declining the vaccine while on campus or while participating in program-related clinical assignments. Should an exposure occur during a classroom or clinical experience, neither the college nor the clinical facility can be held liable and/or responsible for cost incurred. I authorize LTC to disclose a copy of this form to the health care facilities where I will be receiving my clinical instruction. I understand that the information and the disclosure of the information is a necessary component of my clinical instruction requirements.

Student Signature: (required)_____ Date:_____

_____ Date: _____

Parent/Guardian Signature **(required if under age 18)**

6. **Proof of a current season flu shot is required**. A waiver for legitimate medical or religious exemptions is available but must be submitted and approved prior to the start of clinical. Submit a copy of this record.

7. Medical Clearance: Fire Service Training

Dear Occupational Medicine Physician:

Your patient has enrolled in a fire training program. The training may include full "dress out" in firefighting PPE (a respirator and bunker gear). Medical clearance complying with Subpart I; § 1910.134 of the OSHA Respirator Standard is required prior to training because of the remote possibility of an untoward health effect. The cost of this exam must be the responsibility of the student and will not be paid by the college.

Training activities are potentially stressful. Fire Training involves wearing an airtight and watertight respirator and bunker gear which weighs up to 25 pounds. The self-contained breathing apparatus (SCBA) may weigh an additional 35 pounds and is carried by the shoulder straps on the back. Trainees may be required to wear full firefighting PPE for up to one-half hour at a time and perform heavy work tasks such as: pulling hose, climbing ladders, and pulling weights up to 175 pounds. This may take place in hot or cold environments and may be indoors or outdoors.

It is important that your patient be carefully assessed regarding his or her ability to fully participate in the training activities. You should note any conditions that could increase susceptibility to heat stress or affect the use of a respirator. Persons who are clearly unable to perform based upon their medical history or physical examination should be limited in their participation and restrictions noted.

Please review their respirator screening questionnaire, complete a physical examination & pulmonary function testing and review the results with the trainee. Also, please complete this medical clearance form and give it to your patient.

Thank you for your cooperation.

1. **Pulmonary Function** Date of Test: _____(must be within one year of program entry)

   FVC FEV 1-3 within normal limits _____YES _____NO

2. **I have examined this applicant and found him/her to be in good physical condition.**
   Please check **one** of the following:

   _____Medically fit to participate without restrictions using respirators.

   _____Medically fit to participate with the following restrictions:

   _____Medically unfit to participate.

Physician Signature:_____ Date of Exam:_____
(Within one year of enrollment)

Print Name of Physician:_____ Telephone Number:_____

Medical clearance is required prior to participating in the SCBA portion of the program.

I am a student at Lakeshore Technical College and age 18 or older. I authorize Lakeshore Technical College to disclose a copy of this form to the health care facilities where I will be receiving my clinical instruction for the program indicated above. I understand that the information and the disclosure of the information is a necessary component of my clinical instruction requirements. This consent is effective for three years from signature date.

8. Student Signature: (required)_____ Date:_____

_____ Date: _____

Parent/Guardian Signature **(required if under age 18)**

Please hand deliver, Mail or Fax to: LAKESHORE TECHNICAL COLLEGE

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Cleveland WI 53015-1414

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E-mail: Renee.bruckschen@gotoltc.edu