Fort Lee Volunteer Ambulance Corps, Inc.
P.O. Box 1148, Fort Lee, New Jersey 07024

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_____ MI _____ Last Name_____ SSN_____

Address_____ City _____ State_____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Occupation _____

Age_____ Date of Birth _____ Sex ☐ Male ☐ Female Height _____ Weight _____ Blood ☐ A ☐ B ☐ AB ☐ O ☐ Pos ☐ Neg

Emergency Contact Information

_____
Name Relation ship

_____
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 OR have a history or:

Medical History

- ☐ Adverse reaction to serum/drug
- ☐ Alcoholism
- ☐ Allergy (food)
- ☐ Allergy (environmental)
- ☐ Anemia
- ☐ Anxiety/Nervousness
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems/Recurrent pain
- ☐ Blood clots
- ☐ 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 of Low Blood Pressure
- ☐ Insomnia/Trouble Sleeping
- ☐ Intestinal/Stomach Problems
- ☐ Joint Problems (knee, shoulder, elbow etc.)
- ☐ 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
- ☐ 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

Eyes

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

Senses

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

Infectious Diseases

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

Describe any items checked above and/or surgeries:

_____
_____
_____
_____

List any Drug Allergies

_____
_____
_____
_____

The information requested on this form is for the use of Fort Lee Volunteer Ambulance Corps, Inc. and will not be released to anyone without your knowledge and consent except as permitted by law.

Hospitalization & Immunization Record

List any treatments or hospitalizations not previously indicated

_____

_____

_____

Communicable Disease Record

Hepatitis B

List dates of Inoculation

Step #1 date _____

Step #2 date _____

Step #3 date _____

Tetanus Toxoid

Date of last tetanus inoculation _____

Varicella (Chickenpox)

vaccination #1 _____

Have you ever had the disease? ☐ Yes ☐ No

vaccination #2 _____

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

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 the Fort Lee Volunteer Ambulance Corps., Inc. 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 questionnaire and obtain written verification from a physician 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:

_____

_____

_____

_____

I have reviewed the attached medical evaluation form and have performed a physical examination on the above mentioned individual. I find no evidence of injury or illness which would preclude this individual from participating in EMT/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 Fort Lee Vol. Ambulance Corp., Inc. Use Only

Approved for active duty: Yes No _____ Date

_____ Fort Lee Volunteer Ambulance. Corps. Inc. Officer Signature