DOCUMENTATION AND MEDICAL REQUIREMENTS FOR EMT STUDENTS

Welcome and thank you for your interest in the UCLA Center for Prehospital Care EMT Program! This information sheet is provided to help you meet the documentation and medical requirements for the EMT program. These requirements are developed by the Department of Health and Human Services/ Centers for Disease Control and Prevention. In addition to needing the below medical requirements to for your EMT program, our clinical/field affiliates will require the same immunizations in order for you to participate in their program. Finally, employers in the patient health care industry will request these medical requirements as well.

Questions
If there are issues gathering the prerequisites, or any other questions, please contact Pilar Beck at Pbeck@mednet.ucla.edu 310-312-9310. You may be referred to speak to the program coordinator as appropriate.

Medical Services
Your physician’s office should be able to provide everything you need to complete your EMT program prerequisites. For other locations in Los Angeles County please visit the Department of Health Services web site at: www.ladhs.org/clinics/

NAME:_________________ STUDENT ID:_________________ CLASS NUMBER:_________________

ALL requirements must be completed and turned in to your Course Coordinator on the first day of class. Staple this sheet on top of the items being submitted. You may also return completed packets to our EMT Administrative Assistant, Pilar Beck. Late, e-mailed or faxed requirements will not be accepted.

<table>
<thead>
<tr>
<th>Student Requirements</th>
<th>Coordinator Initials</th>
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<tbody>
<tr>
<td>1. Current American Heart Association (AHA) BLS Healthcare Provider Card or Current American Red Cross (ARC) Professional Rescuer Card. (Copy front and back of card.)</td>
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<td>2. Proof of health insurance. (Copy front and back of card.)</td>
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<tr>
<td>3. Proof of Hepatitis B Vaccine (start of 3 shot series AND signed Hepatitis B waiver form included in this packet)</td>
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<td>4. Proof of current measles/mumps/rubella (MMR) immunization or titer.</td>
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<td>5. Proof of current varicella (chicken pox or VZV) immunization or titer. A signed and dated note from a physician is acceptable.</td>
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<td>6. Proof of negative TB skin test, Quantiferon-Gold blood test, or a negative chest x-ray administered within 3 months (2 years for x-ray) prior to the start of the class.</td>
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<tr>
<td>7. Page six of this packet stamped and dated note from a physician within 6 months prior to the start of class specifying that you can participate in the clinical portion of the EMT program without physical limitations. You MUST use the form on page six.</td>
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<tr>
<td>8. Proof of receiving the Flu Vaccine and complete the CPC Flu Vaccine Requirement form. Required between November 1 and March 31.</td>
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For Office Use Only

Policy Cert: ________________ (initial)  Mask Fit Test: ___________ (Initial)

Research Waiver: ____________ (initial)  Clinical Req (Box 37)_______ (Initial)

Photo Release: ________________ (initial)  SRRS Entry by: __________ (Initial)
HEPATITIS B VACCINE VERIFICATION

EMT

☐ I understand that due to my participation as a student in the UCLA EMT Course, I may be at risk for exposure to blood or potentially infectious materials and acquiring the Hepatitis B Virus (HBV) infection. I have been asked to be vaccinated with the Hepatitis B vaccine. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can obtain the vaccination series and will submit documentation of such to the Program while I am enrolled as a student.

I decline the Hepatitis B Vaccination Series due to the following reason(s):  
(Please mark at least one choice)

☐ I am declining because I choose not to have the Hepatitis B vaccination series. I am aware that I may change my mind at a later date.

☐ I have completed the entire series (3) of Hepatitis B vaccinations. I have a record or know the date and location of those vaccinations.  
(Please submit documentation verifying completion of 3-shot series or titer).

☐ I have already completed the entire series of 3 Hepatitis B vaccinations. I do not have a record or cannot recall when I received the vaccinations.

☐ I have a positive titer for Hepatitis B virus.  
(Please submit documentation verifying titer).

☐ Other

________________________________________________________________________

Signature Date

________________________________________________________________________

Print Name

UCLA Center for Prehospital Care

Department

✓ UCLA does not make copies of student records. It is the responsibility of the student to maintain their files.
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MEDICAL EVALUATION QUESTIONNAIRE FOR OSHA RESPIRATOR/MASK FIT TESTING

This questionnaire is to help your physician determine whether you can perform the mask fit (respirator) test in class. The evaluation **must be repeated** if you have a physical change (e.g., significant weight change) in between the original evaluation and the start of class. We encourage you to obtain this clearance at the same time you do your physical. **Completing the Mask Fit Testing in class requires men to shave their facial hair as it may prohibit a mask (respirator) from fitting properly.**

Questionnaire directions for students:
1. Complete the questionnaire.
2. Give the questionnaire and form to your physician or authorized healthcare provider for review/evaluation.
3. The physician will retain the questionnaire for your medical file, and will return the physical & mask fit clearance form.

You are required to confirm that you can read (circle one): Yes / No

Name: ___________________________ Date:_________ Your age (to nearest year): ______ 4. Sex: Male/Female

Height: _____ ft. _____ in. Weight: _______ lbs. Your title: Student  Phone Number ________________

Check the type of respirator you will use (you can check more than one category):

a. ___ ✔ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
   (Note: requires men to shave facial hair, e.g., beard or stubble.)
b. ____ Other type (e.g., half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator (circle one): Yes/No, If "yes," what type(s):__________________________

Section 2. (Mandatory) Questions 1 through 9 below must be answered by every student who has been selected to use any type of respirator (please CIRCLE "yes" or "no" for your answers). Your physician or authorized healthcare provider should ask the student these questions to determine eligibility and retain this answer sheet for their medical files.

1. Do you **currently** smoke tobacco, or have you smoked tobacco in the last month: Yes/No
2. Have you **ever had** any of the following conditions?
   a. Seizures (fits): Yes/No
   b. Diabetes (sugar disease): Yes/No
   c. Allergic reactions that interfere with your breathing: Yes/No
   d. Claustrophobia (fear of closed-in places): Yes/No
   e. Trouble smelling odors: Yes/No
3. Have you **ever had** any of the following pulmonary or lung problems?
   a. Asbestosis: Yes/No
   b. Asthma: Yes/No
   c. Chronic bronchitis: Yes/No
   d. Emphysema: Yes/No
   e. Pneumonia: Yes/No
   f. Tuberculosis: Yes/No
   g. Silicosis: Yes/No
   h. Pneumothorax (collapsed lung): Yes/No
   i. Lung cancer: Yes/No
   j. Broken ribs: Yes/No
   k. Any chest injuries or surgeries: Yes/No
   l. Any other lung problem that you've been told about: Yes/No

✔ This form is to be retained by your physician.
4. Do you **currently** have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath: Yes/No
   b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
   c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
   d. Have to stop for breath when walking at your own pace on level ground: Yes/No
   e. Shortness of breath when washing or dressing yourself: Yes/No
   f. Shortness of breath that interferes with your job: Yes/No
   g. Coughing that produces phlegm (thick sputum): Yes/No
   h. Coughing that wakes you early in the morning: Yes/No
   i. Coughing that occurs mostly when you are lying down: Yes/No
   j. Coughing up blood in the last month: Yes/No
   k. Wheezing: Yes/No
   l. Wheezing that interferes with your job: Yes/No
   m. Chest pain when you breathe deeply: Yes/No
   n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you **ever had** any of the following cardiovascular or heart problems?
   a. Heart attack: Yes/No
   b. Stroke: Yes/No
   c. Angina: Yes/No
   d. Heart failure: Yes/No
   e. Swelling in your legs or feet (not caused by walking): Yes/No
   f. Heart arrhythmia (heart beating irregularly): Yes/No
   g. High blood pressure: Yes/No
   h. Any other heart problem that you've been told about: Yes/No

6. Have you **ever had** any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: Yes/No
   b. Pain or tightness in your chest during physical activity: Yes/No
   c. Pain or tightness in your chest that interferes with your job: Yes/No
   d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
   e. Heartburn or indigestion that is not related to eating: Yes/No
   f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you **currently** take medication for any of the following problems?
   a. Breathing or lung problems: Yes/No
   b. Heart trouble: Yes/No
   c. Blood pressure: Yes/No
   d. Seizures (fits): Yes/No

8. If you've used a respirator, have you **ever had** any of the following problems? (If you've **never** used a respirator, check the following space and go to question 9)
   a. Eye irritation: Yes/No
   b. Skin allergies or rashes: Yes/No
   c. Anxiety: Yes/No
   d. General weakness or fatigue: Yes/No
   e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to these questions? Yes/No

✓ **This form is to be retained by your physician.**
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Physical & Mask Fit Testing Clearance Form
(To be completed by physician or authorized provider)

Student Name: ___________________________  DOB: ____________

<table>
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<th>Physical Requirements for EMT Students</th>
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<tbody>
<tr>
<td>Physical Demands on EMT Students: Aptitudes required for work of this nature are good physical stamina, endurance, and body condition that would not be adversely affected by frequently having to walk, stand, lift, carry, and balance at times. Hand-Eye and motor coordination is necessary. The work can involve light lifting (from 10 to 20 pounds maximum) to very heavy lifting (50 pounds frequently, no maximum) and can involve climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, feeling, talking, hearing, and seeing.</td>
</tr>
</tbody>
</table>

☐ Please check this box if the above named student is medically clear to participate in the skills and clinical portions of the EMT program as outlined above.

☐ Please check this box if the above named student is medically clear to participate in the mask fit testing for the EMT program without limitations.

Printed name of provider: ____________________________________________

Address: __________________________________________________________________

Telephone number: __________________________________________________________________

Provider’s signature: ___________________________  Date: _________________

If there are limitations, please list them here:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

☑ To be turned in to EMT Program Coordinator.

☑ UCLA does not make copies of student records. It is the responsibility of the student to maintain their files.
FLU VACCINE REQUIREMENT

For the period of 11/1 – 3/31, UCLA EMT students must be in compliance with the LA County Public Health order for all persons in patient care areas to either have the flu vaccine or wear a mask.

MANDATORY FLU VACCINE SURVEY

If you have received your flu vaccine OR even if you are not going to get vaccinated please complete the mandatory flu survey. The on-line survey is needed in addition to submitting this form to your program.

To access the survey click here: https://hshr.mednet.ucla.edu/s/flusurvey/2013fluvacsurveyid.asp

- If you don't have a UCLA undergraduate/graduate student or employee ID, click the link provided on that page for those without and employee ID or temporary ID.

- For the “Affiliation,” click on your program: GPC EMT Student

FLU VACCINE VERIFICATION

I understand that due to my participation in clinicals as a student in the UCLA EMT Program during any time from 11/1 to 3/31, I have been asked to be vaccinated against the flu.

However, I decline this vaccination at this time for the following reason (mark at least one choice):

- I have already received a flu vaccination. I have a record or know the date and location done of that vaccination. (Please submit documentation verifying the vaccination)

- I have already received a flu vaccination. I do not have record or cannot recall when I received the vaccination.

- I am declining because I choose not to have the flu vaccination. I understand that without the vaccine, I am required to wear a mask while in contact with patients or working in patient care areas during my clinicals and internships for the program. This includes patient rooms, exam room, emergency department bay areas, etc. I understand that by declining the vaccine, I continue to be at risk of acquiring the flu. I am aware that I may change my mind about the vaccine at a later date. I can obtain the flu vaccination in the future while enrolled as a student and will then submit the documentation to the program.

- Other: ____________________________________________________________

________________________________________
Signature Date

________________________________________
Print Name

UCLA Center for Prehospital Care

Department

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