

New Hampshire Fire Explorer Training Academy

P.O. Box 1225 · Manchester, New Hampshire · 03105-1225 · (603) 352-7633

2006 Health / Medical Form

Since firefighting is a physical activity, all participants of the New Hampshire Fire Explorer Training Academy are required to have appropriate medical forms with completed information. **A physical examination must be completed by a licensed health care practitioner (MD, DO, ARNP, PA) within 1 year prior to the start of the academy. This form must be signed by a licensed healthcare practitioner within 6 months prior to registration of the academy.** Under no circumstance will an Explorer be permitted to register at the academy without a properly completed medical form. **Please carefully complete each section of this form as instructed and return to the above address no later than June 1, 2006.** Keep a copy of the completed form for your records in case an additional form is needed.

Personal Information (Please print clearly)

Legal Name: _____ Gender: Male Female
Street Address: _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Social Security #: _____
Date of Birth: ___/___/___ Age as of 06/24/06: _____ Religion: _____
Primary Care Physician: _____ Phone: _____

Health Insurance **OR** No Health Insurance Coverage (please check one)

Health Insurance Carrier/Company: _____
Name of Subscriber: (parent carrying insurance): _____
Insurance Policy #: _____

Emergency Contact Information

Name of Contact #1: _____ Relationship: _____
Day Phone: _____ Night Phone: _____
Cell Phone: _____ Pager: _____

Name of Contact #2: _____ Relationship: _____
Day Phone: _____ Night Phone: _____
Cell Phone: _____ Pager: _____

Immunization History

Please record dates of most recent immunizations. Fill in N/A if not applicable or "D" for disease or check the following box. Please see immunization record provided.

Diphtheria		H. Influenza		Measles	
Pertussis		Polio		Mumps	
Tetanus		TB Test		Rubella	
Chicken Pox		Hepatitis B			

Health / Medical History

This participant has not experienced any previous medical conditions and is not experiencing any medical conditions currently

Check all conditions this participant has been diagnosed with/experienced in the past or is currently under the care of a health care professional for. Please give details and approximate date of onset on the line next to the condition.

<input type="checkbox"/> Serious injury	_____	<input type="checkbox"/> Head Injury	_____
<input type="checkbox"/> Deformity	_____	<input type="checkbox"/> Convulsions/Seizures	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Stomach/Bowels	_____
<input type="checkbox"/> Chest/Lungs	_____	<input type="checkbox"/> Appendicitis	_____
<input type="checkbox"/> Heart Murmur	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Abnormal Heart Rate	_____	<input type="checkbox"/> Hernia	_____
<input type="checkbox"/> Dysrhythmia	_____	<input type="checkbox"/> Kidneys/Urine	_____
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Menstrual Problems	_____
<input type="checkbox"/> Bleeding Disorders	_____	<input type="checkbox"/> Back/Limbs/Joints	_____
<input type="checkbox"/> Fainting	_____	<input type="checkbox"/> Depression	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> ADHD/ADD	_____
<input type="checkbox"/> Skin/Glands	_____	<input type="checkbox"/> Anxiety	_____
<input type="checkbox"/> Ears/Eyes	_____	<input type="checkbox"/> Sleepwalking	_____
<input type="checkbox"/> Ear Infections	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Nose/Sinus/Throat	_____	<input type="checkbox"/> Other Infection	_____
<input type="checkbox"/> Teeth/Tonsils	_____	<input type="checkbox"/> Other Illness	_____

Please list any additional health information, including surgeries, or dietary restrictions below:

Allergies

No Known Allergies for this participant

Please check all that apply and list type of reaction next to allergen.

<input type="checkbox"/> Iodine	_____	<input type="checkbox"/> Sulfa Drugs	_____	<input type="checkbox"/> Latex	_____
<input type="checkbox"/> Pollen	_____	<input type="checkbox"/> Erythromycin	_____	<input type="checkbox"/> Other Meds	_____
<input type="checkbox"/> Poison Ivy	_____	<input type="checkbox"/> Amoxicillin	_____	<input type="checkbox"/> Animals	_____
<input type="checkbox"/> Insect Stings	_____	<input type="checkbox"/> Penicillin	_____	<input type="checkbox"/> Food	_____

Please explain food or other allergies not listed above: _____

Does this participant require immediate medical attention for allergies listed? YES NO

Please specify treatment: _____

Does this participant require Epinephrine? YES NO **Please send Epi-Pen with participant**

Medications

This participant does not require any medications. (Please check here if this statement is appropriate)

Please list ALL (prescription and over the counter) medications this participant routinely takes.

Bring enough medication for the week of the academy. Keep medication in original container, which identifies the name of the medication, dosage and frequency of administration. Please label over the counter medications with participant's name, dosage and frequency of administration. Medications are administered according to directions on the container. Additional information can be provided to staff in a sealed envelope.

Medication Name	Dosage	Frequency	Specific Times Taken	Reason for Taking

Parental Statements/ Releases/ Authorizations

Please carefully read all of the information below and sign the appropriate lines. If participant is 18 years of age or older he/she may sign in appropriate areas. However, if participant is under 18 years of age a parent or legal guardian must complete these forms and sign in the designated areas.

I give permission to the selected New Hampshire Fire Explorer Training Academy staff or volunteer to administer the medications listed previously in this form as well as any of the following medications that I have indicated with a check mark, should the staff or volunteer deem necessary.

All of the medications listed Or None of the medications listed Or Select medications below

Acetaminophen
 Calamine Lotion
 Naproxen

Insect Repellant
 Immodium AD
 Ibuprofen

Cough Drops
 Pepto Bismol
 Benadryl

Neosporin
 Aspirin
 Sunscreen

Signature of Parent/Guardian

Print Name of Parent/Guardian

Date

Signature of Applicant

Print Name of Applicant

Date

To the best of my knowledge, the information provided in this medical form is accurate and complete. I request a licensed health care practitioner to examine applicant, to give needed immunizations and to furnish requested information to other agencies as needed. I give my permission for full participation in the New Hampshire Fire Explorer Training Academy, subject to limitations noted herein. In the event of illness or accident in the course of such academy, I request that measures be instituted without delay as judgment of medical personnel dictates. Should any of the information provided in this medical form change or be deemed inaccurate I will notify the staff of the New Hampshire Fire Explorer Training Academy prior to the applicant's registration into the academy. Furthermore, should the applicant's medical status/condition change I will notify the staff of the academy prior to the applicant's arrival to registration.

Signature of Parent/Guardian

Print Name of Parent/Guardian

Date

Signature of Applicant

Print Name of Applicant

Date

I hereby give permission to the staff of New Hampshire Fire Explorer Training Academy to release records necessary for insurance purposes, emergency care or continuity of care. I also give permission for the staff of the said academy to provide or arrange necessary related transportation for my child. In the event that the listed emergency contact persons cannot be reached in an emergency, I hereby give permission for medical personnel selected by New Hampshire Fire Explorer Training Academy to secure and administer treatment including hospitalization for the participant named above. I further understand that I will be responsible for any medical/hospital bills.

Signature of Parent/Guardian

Print Name of Parent/Guardian

Date

Signature of Applicant

Print Name of Applicant

Date

Health / Physical Examination

The following information is to be completed and signed by an appropriate Licensed Health Care Practitioner (MD, DO, ARNP, PA)

Instructions for Licensed Health Care Practitioner:

Please note – During this firefighting academy the applicant will be participating in strenuous activity that will include one or more of the following conditions: athletic competition, adventure challenge, wilderness expeditions that may include high altitude, extreme weather and temperature conditions, coldwater, exposure to cold and heat and fatigue.

Please review the information provided in this medical form including medical history, medications, allergies and immunization history. Please administer immunizations if not current.

After reviewing the above information, please complete the following information and summarize any restrictions and or/recommendations below and sign. Thank you in advance.

Date of most recent Physical Examination: _____ (must be between 06/24/05 and 06/01/06)

Height: _____ Vision: _____ Hearing: _____ Lab Results:
Weight: _____ Requires glasses Requires Hearing Aids N/A
Temp: _____ Wears Contacts Normal
Pulse: _____ Abnormal*
Blood Pressure: _____ *please comment on abnormal findings below

Please check box if system is normal; circle if abnormal and give details below:

<input type="checkbox"/> Growth, development	<input type="checkbox"/> Teeth, tonsils	<input type="checkbox"/> Genitourinary
<input type="checkbox"/> Skin, glands, hair	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Musculoskeletal
<input type="checkbox"/> Head, neck, thyroid	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Neurological
<input type="checkbox"/> Eyes, ears, nose	<input type="checkbox"/> Abdomen, hernia, rings	<input type="checkbox"/> Behavior, psychiatric

Comments: _____

Has there been any surgery, injury, illness, allergy or change in health status since last complete physical examination? YES NO

If yes, please explain: _____

I have examined _____ (name of applicant) as noted above.
This individual is allowed to participate in this program without restriction. YES NO
Please specify restrictions/limitations or recommendations if appropriate: _____

Signature of Health Care Practitioner

Printed Name of Practitioner

Date