SCHOOL DISTRICT OF HILLSBOROUGH COUNTY, FLORIDA
Aparicio-Levy Technical College

PHYSICAL EXAMINATION FORM FOR EMT STUDENTS – August 2025

(Physicals are good for one calendar year.)

THIS SECTION TO BE COMPLETED BY STUDENT PRIOR TO EXAMINATION

Last Name: _____ **First Name**_____ **Birthdate:** ___/___/_____

Address: _____ **Phone:** (____)_____

Number & Street *City* *State* *Zip Code*

I understand that I may be asked to submit additional data: _____

Student's Signature

THIS SECTION TO BE COMPLETED BY EXAMINER

BLOOD PRESSURE: ____ TEMP:_____ PULSE:_____ RESP. RATE:_____ HEIGHT:_____ WEIGHT:_____

VISION - Right eye with glasses: _____ VISION - Right eye without glasses: _____

VISION - Left eye with glasses: _____ VISION - Left eye without glasses: _____

HEARING SCREENING: Forced whisper at 5 feet: ☐ Pass ☐ Fail

REVIEW OF SYSTEMS:

ENT Findings:	☐ Positive Findings ☐ Negative	GU/Reproductive:	☐ Positive Findings ☐ Negative Findings
Respiratory: Findings	☐ Positive Findings ☐ Negative	Neuro/Muscular:	☐ Positive Findings ☐ Negative Findings
Cardiovascular: Findings	☐ Positive Findings ☐ Negative	Endocrine:	☐ Positive Findings ☐ Negative Findings
GI: Findings	☐ Positive Findings ☐ Negative	Integumentary: Findings	☐ Positive Findings ☐ Negative

Explanation of Positive Findings:

Do you consider this person to be physically capable of performing the duties required in the EMT program, as stated on the back of this form?

☐ Yes, I agree that this individual can do the Core Performance Standards **☐ No**

_____ _____ _____

Examining Physician / PA / Nurse Practitioner SIGNATURE Date Name of Medical Facility

_____ _____ _____

Examiner's Printed Name Phone Number Address

EMT CORE PERFORMANCE STANDARDS

Issue	Standard	Some Examples of Necessary Activities (not all inclusive)
Critical Thinking	Critical thinking ability sufficient for clinical judgment.	Identify cause-effect relationship in clinical situations. Develop patient treatment plans.
Interpersonal	Interpersonal abilities sufficient to interact with individuals, families, and groups from a variety of social, emotional, cultural, and intellectual backgrounds.	Establish rapport with patients/clients and colleagues.
Communication	Communication abilities sufficient for interaction with others in verbal and written form.	Explain treatment procedures, initiate health teaching document and interpret treatment strategies and patient/client responses.
Mobility	Physical abilities sufficient to move from room to room, maneuver in small spaces, and navigate stairwells.	Move around in patient's rooms, homes, ambulances, work spaces, and treatment areas, administer medications, and lift a minimum of 125 pounds.
Motor Skills	Gross and fine motor abilities sufficient to provide safe and effective emergency care.	Calibrate and use equipment; position patients/clients.
Hearing	Auditory ability sufficient to monitor and assess health needs.	Hear monitor alarm, emergency signals, auscultatory sounds, cries for help, etc.
Visual	Visual ability sufficient for observation and assessment necessary in emergency care.	Observe patient/client responses.
Tactile	Tactile ability sufficient for physical assessment.	Perform palpation, functions of physical examination and/or those related to therapeutic intervention, e.g., insertions of an intravenous catheter, etc.

INDIVIDUALS WITH A DISABILITY:

For the purpose of the Emergency Medical Technician (EMT) program, a "Qualified individual with a disability is one who, with or without reasonable accommodation or modification, meets the essential eligibility requirements for participation in the program."

EMT is a practice discipline with cognitive, sensory, affective, and psychomotor performance requirements. Based on these requirements, a list of "Core Performance Standards" has been developed. Each standard has an example of an activity which a student will be required to perform while enrolled in the program. These standards should be used to assist students in determining whether accommodations or modifications are necessary for a student to meet program requirements. Students who identify potential difficulties with meeting the Core Performance Standards must communicate their concerns to the counselor and/or program advisor. Determination is made on an individual basis as to whether or not the necessary accommodations or modifications can be reasonably made.

Medical provider (doctor or nurse) completes this page.

1 - MAN-TOUX PPD TUBERCULIN TEST *(Must be valid through the END of the program: 12/19/2025)*	**Date TB Test was read**	**Test Results***
**Note: If Tuberculin Skin Test is positive, a chest X-ray must be done.*	Date x-ray was taken	Results

2 - RUBEOLA AND RUBELLA: Proof of immunity by ***ONE*** of the following: shot record, titers or current vaccinations:

Measles/Mumps/Rubella - MMR (2 doses) Date: _____ Date: _____

OR:

Rubeola (Measles): 2 doses live vaccine administered on or after first birthday Date: _____ Date: _____

Rubella (German Measles): 1 dose live vaccine administered on or after first birthday Date: _____

OR: *Titer*

Rubeola (Measles) Date: _____ Level: _____

Rubella (German Measles) Date: _____ Level: _____

If unable to document immunity through past vaccinations or through titer, student must receive the following vaccinations:

OR: *Vaccinations*

Rubeola (Measles): 2 doses at least 30 days apart Date: _____ Date: _____

Rubella (German Measles): 1 dose Date: _____

3 - TDaP – Tetanus, Diphtheria, Pertussis Date: _____

*Proof of TDaP vaccination within the past **ten years** must be shown through doctor's statement or "shot" record*

For HEPATITIS B and VARICELLA, applicant may choose to have a titer completed.
Vaccine recommended if titer does not show immunity. Or applicant may decline vaccination by signing below.

4 - HEPATITIS B Titer: Date: _____ Results: _____

OR: Vaccine (3 doses) Date: _____ Date: _____ Date: _____

OR: *I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline 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 and potentially life-threatening disease.*

Student's Signature (if declining vaccination): _____ Date: _____

5 - VARICELLA (CHICKENPOX) Has had chickenpox: ☐ Yes, Date: _____ ☐ No

Titer (***required*** if applicant has not had chickenpox) Date: _____ Results: _____

OR: Vaccination (2 doses recommended) Date: _____ Date: _____

OR: *At this time, I decline the Varicella vaccinations. I understand that I do not have immunity against chickenpox and may not go into rooms with patients who have chickenpox or shingles.*

Student's Signature (if declining vaccination): _____ Date: _____

6 - INFLUENZA (FLU) Students must get a flu shot for **FALL 2025** season when it's available (usually mid-August). Check with your provider for availability.

Lot # _____ *Expiration date* _____ *Date of Administration* _____

I certify that the above tests and/or vaccinations were performed in this office or laboratory, OR have been verified from a shot or medical record.

_____ _____ _____

Examining Physician / PA / Nurse Practitioner SIGNATURE | Date | Name of Medical Facility

_____ _____ _____

Examiner's Printed Name | Phone Number | Address

HEALTH HISTORY

Student is to complete this form

Last Name: _____ **First Name**_____ **Birthdate:** ___/___/_____

Address: _____ **Phone:** (____)_____

Number & Street *City* *State* *Zip Code*

Have you had any serious injuries or operations within the past three years that would inhibit you from performing the core standards listed on page 2? ☐ Yes ☐ No

If yes, please explain:

CHECK ANY OF THESE CONDITIONS WHICH APPLY TO YOU:

- ☐ Bone injury or other problems that prohibit lifting 125 lbs.
- ☐ Diabetes
- ☐ Hearing problems (surgery, hearing aid, other treatment)
- ☐ Heart disease
- ☐ Problems bending frequently
- ☐ Problems pushing objects over 100 pounds
- ☐ Seizures (convulsions, epilepsy)
- ☐ Trouble standing or walking for long periods (4-6 hours)
- ☐ Vision problems (glasses, surgery, color blindness or other treatment)
- ☐ Do you have any physical or mental limitations that keep you from fulfilling the requirements of the Core Performance Standards listed on page 2? ☐ Yes ☐ No

If yes, please explain:

I have read the Student Information sheet and attest to the truth of my responses on this form. I will notify the school of any changes in my physical status. I understand that this physical must be valid for 1 year and through the end of the EMT program.

Student's Signature: _____ Date: _____

Note: Some Clinical Partners mandate the COVID-19 vaccination for their employees. If this extends to students, you will NOT be able to participate in required clinical experiences unless you are vaccinated. This will prevent your successful completion of the program.

I have been vaccinated: ☐ Yes ☐ No Date(s) of vaccination: _____

- If you ARE vaccinated, bring in proof of your vaccination.
- If you ARE NOT vaccinated, please provide a medical or religious exemption form, which can be found on our website.

Students that do not have the COVID-19 vaccination and do not wish to receive the vaccination MAY be able to participate at the discretion of the clinical partner.