HEALTH EXAMINATION PACKET – **EMT INTERMEDIATE TECHNICIAN**

The next step in the admissions process is a health examination and completion of the required forms listed below. Please return all signed forms to the MATC Nursing Center in Room M240. The cost of the health examination and immunizations are your responsibility. You may be able to obtain health care services at your local Health Department.
Included in this packet are:

1. Health Certification Form. Please have your physician or health care provider complete and sign the enclosed Health Certification Form.

2. Information about Hepatitis B and its vaccine, and a Hepatitis B Release Form. Please read the information and discuss it with your physician. Complete and sign the Hepatitis Release Form.

3. Information about the Essential Functions for your program. Please read the information. If you have questions, discuss it with your physician. Complete and sign the Essential Functions Form.

All forms must be completed with authorized signatures.

Return the completed Health Certification Form, the Hepatitis B Release Form and the Essential Functions Form to the MATC Nursing Center in Room M240 no later than_____.
If you have any questions, please contact the Nursing Center at 414-297-7871. **Be sure to keep a copy of your completed forms**. Please notify the Admissions Office at 414-571-4566 between 8am and 4pm regarding any change of name, address, or telephone number. We look forward to working with you as you complete your enrollment in your program at MATC.

FUNCTIONAL ABILITY CATEGORIES
&
REPRESENTATIVE ACTIVITIES/ATTRIBUTES FOR THE
EMT Intermediate Technician

The Federal American's with Disabilities Act (ADA) bans discrimination of persons with disabilities. In keeping with this law, MATC makes every effort to ensure quality education for all students. However, we feel obligated to inform students of the functional abilities demanded by a particular occupation. The following physical, cognitive and environmental factors are encountered by EMT Intermediate Technician students in training and by the EMT Intermediate Technician in the workforce:

FUNCTIONAL ABILITY CATEGORIES
&
REPRESENTATIVE ACTIVITIES/ATTRIBUTES FOR THE
EMT Intermediate Technician Program

Gross Motor Skills:	Move within confined spaces Maintain balance in multiple positions Reach above shoulders (e.g., IV poles) Reach out front
Fine Motor Skills:	Pick up objects with hands Grasp small objects with hands (e.g., IV tubing, pencil) Write with pen or pencil Key/type (e.g., use of computer) Pinch/pick or otherwise work with fingers (e.g., manipulate a syringe) Twist (e.g., turn objects/knobs using hands) Squeeze with finger (e.g., eye dropper)
Physical Endurance:	Stand (e.g., at client side during surgical or therapeutic procedure) Sustain repetitive movements (e.g., CPR) Maintain physical tolerance (e.g., work on your feet a minimum of 8 hours)
Physical Strength:	Push and pull 50 pounds (e.g., position client, move equipment) Support 50 pounds of weight (e.g., ambulate client) Lift 50 pounds (e.g., pick up a child, transfer client, bend to lift an infant or child) Carry equipment/supplies Use upper body strength (e.g., perform CPR, physically restrain a client) Squeeze with hands (e.g., operate fire extinguisher)

Mobility:	Twist Bend Stoop/squat Move quickly (e.g., response to an emergency) Climb stairs Walk
Hearing:	Hear normal speaking-level sounds (e.g., person-to-person report) Hear faint voices Hear faint body sounds (e.g., blood pressure sounds, assess placement of tubes) Hear in situations when not able to see lips (e.g., when masks are use) Hear auditory alarms (e.g., monitors, fire alarms, call bells)

Visual:	See objects up to 20 inches away (e.g., information on computer screen, skin conditions) See objects up to 20 feet away (e.g., client in room) Use depth perception Use peripheral vision Distinguish color and color intensity (e.g., color codes on supplies, flushed skin/paleness)
Tactile:	Feel vibrations (e.g., palpate pulses) Detect temperature (e.g., skin, solutions) Feel differences in surface characteristics (e.g., skin turgor, rashes) Feel differences in sizes, shapes, (e.g., palpate vein, identify body landmarks) Detect environmental temperature
Smell:	Detect odors (e.g., foul smelling drainage, alcohol breath, smoke, gasses or noxious smells)
Environment:	Tolerate exposure to allergens (e.g., latex gloves, chemical substances) Tolerate strong soaps Tolerate strong odors
Reading:	Read and understand written documents (e.g., flow sheets, charts, graphs) Read digital displays
Math:	Comprehend and interpret graphic trends Calibrate equipment Convert numbers to and from metric, apothecaries', and American systems (e.g., dosages) Tell time Measure time (e.g., count duration of contractions, CPR, etc.) Count rates (e.g., drips/minute, pulse) Read and interpret measurement marks (e.g., measurement tapes and scales) Add, subtract, multiply, and/or divide whole numbers Compute fractions and decimals (e.g., medication dosages) Document numbers in records
Emotional Stability:	Establish professional relationships Provide client with emotional support Adapt to changing environment/stress Deal with the unexpected (e.g., client condition, crisis) Focus attention on task Cope with own emotions Perform multiple responsibilities concurrently Cope with strong emotions in others (e.g., grief)

Analytical Thinking:	Transfer knowledge from one situation to another Process and interpret information from multiple sources Analyze and interpret abstract and concrete data Evaluate outcomes Problem solve Prioritize tasks Use long-term memory Use short-term memory

Critical Thinking:	Identify cause-effect relationships Plan/control activities for others Synthesize knowledge and skills Sequence information Make decisions independently Adapt decisions based on new information
Interpersonal Skills:	Establish rapport with individuals, families, and groups Respect/value cultural differences in others Negotiate interpersonal conflict
Communication Skills:	Teach (e.g., client/family about health care) Influence people Direct/manage/delegate activities of others Speak English Write English Listen/comprehend spoken/written word Collaborate with others (e.g., health care workers, peers) Manage information

EMT INTERMEDIATE TECHNICIAN
Essential Functions Signature Form

The Americans with Disabilities Act bans discrimination of persons with disabilities and in keeping with this law, MATC makes every effort to insure quality education for all students. It is our obligation to inform students of the functional abilities demanded by this program and occupation. Students requiring accommodation or special services to meet the physical, cognitive and/or environmental performance standards of the EMT Intermediate Technician program should contact the Special Needs Department for assistance (Room C219).

_____ I require the following accommodations to meet the functional abilities as specified.

(Signed) (Date)

10/26/06

MATC is an Affirmative Action/Equal Opportunity Institution and complies with all requirements of the Americans with Disabilities Act

MILWAUKEE AREA TECHNICAL COLLEGE
EMT INTERMEDIATE TECHNICIAN
Statement of Understanding
<u>This form is to be completed upon admission to the program</u>.

_____ I have read and I understand the *Functional Ability Categories* specific to a student in an (initials) EMT Intermediate program.

_____ I am able to meet the *Functional Abilities* as presented, and have been provided with (initials) information concerning accommodations or specific services if needed at this time.

Name of Student (Please print & sign) Date

The applicant must: 1). Return the original complete form to MATC, Nursing Center, Room M240. Name_____
2). Retain a copy to show instructor.

Program_____

MILWAUKEE AREA TECHNICAL COLLEGE
700 WEST STATE STREET
MILWAUKEE, WISCONSIN 53233

HEALTH CERTIFICATION

(Print Name and Address)

NAME:_____ **BIRTHDATE:**_____/_____/_____

ADDRESS:_____ **City/State** _____ **Zip Code** _____

PROGRAM NAME:_____**Semester Start**_____ **TELEPHONE #:**_____

Cell Phone #: _____ **E-Mail Address:** _____

STUDENT ID # or SS# :_____ **DATE DUE:**_____
This form must be completed and returned by the above stamped date

Were you in another Health Occupations program? ☐ Yes or ☐ No

If yes, what program? _____**Date you were in program** _____

ONLY PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER, TO COMPLETE THE FOLLOWING:

I have examined _____ **and certify that she/he is in good physical and mental health.**
Student's Name
On letterhead stationary, please list any physical limitations or other disabilities which would limit this individual's capacity to perform the essential functions of this profession. (See attached)

Physicians, Physician Assistant or Nurse Practitioner SIGNATURE & Medical Title

_____ **Date**_____

Print Professional's Name_____**Office Telephone #**_____

Address_____
Street **City** **State** **Zip Code**

A full exam is on file at _____

IMMUNIZATIONS

Proof of at least two MMR's on or after the first birthday at least 30 days apart or laboratory evidence of rubella and measles immunity.

1) MMR _____ _____
Date **Authorized Signature & Medical Title**

2) MMR _____ _____
Date **Authorized Signature & Medical Title**

OR

Rubella Titer _____ _____ _____
Results **Date** **Authorized Signature & Medical Title**

AND

Rubeola Titer _____ _____ _____
Results **Date** **Authorized Signature & Medical Title**

The applicant must: 1). Return the original complete form to MATC, Nursing Center, Room M240. Name_____
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Program_____

CHICKEN POX

Must have documentation of Health Care Provider Diagnosed Chicken Pox. If no documentation is available, must have a positive titer or documentation of vaccination.

RESULTS

Has this patient had:

Chicken Pox	_____	_____	_____	_____
	Yes	**No**	**Date**	**Authorized Signature & Medical Title**
OR				
Varicella Vaccine	**#1.** _____			_____
	Date			**Authorized Signature & Medical Title**
30 days laters	**#2.** _____			_____
	Date			**Authorized Signature & Medical Title**
OR				
Varicella Titer	_____	_____		_____
	Date	**Results**		**Authorized Signature & Medical Title**

TWO STEP MANTOUX TUBERCULIN SKIN TEST: This must be administered within one year of date of program entry or, if over one year, a ONE step update must be performed. Nursing Assistant Students must have skin test within 90 days of program beginning date.

PROCEDURE:

Step 1:

1). **A Mantoux Tuberculin Skin Test of 0.1 (STU) PPD is administered to all individuals who have never had a two-step skin test or to those individuals who have not had a PPD within the last two years.**

2). **A health care professional must read the results within 48-72 hours.**

If positive, must follow- up with a chest x-ray.

Step 2

1). **Repeat the test within 7 to 30 days after the application of the first dose using the same strength of PPD.**

2). **A health professional must read the results within 48-72 hours.**

If positive, must follow-up with a chest x-ray.

If negative, repeat (Step 1only) each year.

REPORTING RESULTS

1. Step 1 Results

_____	_____	_____	_____
Date Administered	**Date Read**	**Results**	**Authorized Signature and Medical Title**

2. Step 2 Results

_____	_____	_____	_____
Date Administered	**Date Read**	**Results**	**Authorized Signature and Medical Title**

3. ANNUAL UPDATE

_____	_____	_____
Date Administered	**Results**	**Authorized Signature and Medical Title**

4. CHEST X-RAY (indicated only when Tuberculin Skin Test is Positive)

_____	_____	_____	_____
Date Administered	**Date Read**	**Results**	**Authorized Signature and Medical Title**

The applicant must: **1). Return the original complete form to MATC, Nursing Center, Room M240.** **Name**_____
2). Retain a copy to show instructor.

Program_____

Proof of Tetanus Immunization: (Within 10 years of program entry)

_____ _____
Date **Authorized Signature and Medical Title**

PLEASE NOTE: You MUST make a copy of your completed health form and retain it. You may need to provide it to a clinical agency.

IMPORTANT

DO NOT RETURN UNLESS ALL RESULTS AND SIGNATURES ARE COMPLETE.

I give permission to release information on this health form to the professional college and clinical affiliate staff if it is deemed necessary for the benefit and/or safety of myself and others.

Signature of Student _____

INSTRUCTIONS TO STUDENTS

- **Did your doctor or authorized medical person sign every authorized signature, dates and results of tests?**
- **Is your physical exam completed and all necessary information on the form completed? i.e. (signature, print name, address, telephone #, test results, etc.)**
- **Do we have your home phone # on the space provided?**
- **Do you have a copy?**

IF YOU HAVE ANY QUESTIONS, CALL THE NURSING CENTER

Joe Tuttle, at 414-297-7871
(Leave message if Joe Tuttle is unavailable)

OR
call
Nursing Center Reception Desk
414-297-6482
between the hours of
8:30 a.m. – 12:30 p.m.
Monday - Thursday

(s|admin\HLTHFRM2)
(Revised 2/11/03:vm)

The applicant must: **1). Return the original complete form to MATC, Nursing Center, Room M240.** **Name**_____
2). Retain a copy to show instructor.

Program_____

MILWAUKEE AREA TECHNICAL COLLEGE

Health Occupations Division

INFORMATION ABOUT HEPATITIS B VACCINES

This general information is provided as a courtesy and matc makes no representation as to it's accuracy. You should consult your physician for all medical information regarding the matters generally described here.

The Disease and the Risks

Hepatitis B is a viral infection caused by the Hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with Hepatitis B recover completely, but approximately 2-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer Thus, immunization again Hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

Risk of Exposure

Medical and paramedical personnel are at increased risk of contracting hepatitis depending upon their degree of exposure to the blood or body fluids(e.g. saliva, feces, sweat, vaginal secretions, respiratory secretions and other body secretions) of patient infected with Hepatitis B (known or unknown). Hepatitis B is spread by direct contact of broken skin or mucus membranes with the blood or body fluids of a person who has Hepatitis B or is a carrier of the disease. Routine or frequent handling of blood or contaminated tissue products, therefore, constitutes significant risk because of the ease of transmission of the disease and the fact that many people with Hepatitis B have no symptoms and do not know they have the disease.

The first line of defense against Hepatitis B is the Hepatitis B vaccine Immunization with Hepatitis B vaccine is the most effective method of preventing HBV infection.

The applicant must: **1). Return the original complete form to MATC, Nursing Center, Room M240.** **Name**_____
2). Retain a copy to show instructor.

Program_____

The Vaccine

The Hepatitis B vaccine (Engerix B, Recombivax HB) is produced using recombinant DNA technology. The vaccine works by stimulating the immune system to produce antibodies tot he virus.

The vaccine is given intramuscularly in the deltoid in three doses. The second dose one month a after the first, and the third dose six- twelve months after the first. After vaccination, more than 90% of healthy adults develop protective antibodies. The cost is $150.00 for the series. Only minor adverse reactions have been reported with vaccination, including transient fever and soreness at the injection site, rash, nausea joint pain and mild fatigue have also been reported.
The vaccine is not contraindicated in pregnancy.

Reference

a. Ganza, a., Torshner, L. (1997) Hepatitis Update. RN, 60 (12), 39-44.

b. Hepatitis B Virus Vaccine Safety: Report of an Interagency Group: MMWR 31(34): 465 September 3, 1982.

c. Hollinger, F. Blaine: Hepatitis B Vaccines-To Switch or Not to Switch. JAMA 257 (19): 2634-2636, May 15, 1987.

d. Inactivated Hepatitis B Virus Vaccine: Annual of Internal Medicine 97:379-83, 1982.

e. Jilg, W., et.a.: Clinical Evaluation of a Recombinant Hepatitis B Vaccine. The Lancet: 1174-1175, November 24, 1984.

f. Krugman, Saul: The Newly Licensed Hepatitis B Vaccine. JAMA 247 (14): 2012-15, April 1992.

g. Leads from the MMWR: Recommendations of the Immunization Practices Advisory Committee Update on Hepatitis B Prevention. JAMA 258(4): 437-449, July 24/31, 1987.

h. Lewis, S., Heitkemper, M., Dirkson, S., (2000). Medical Surgical Nursing. 1193-1198. Mosby.

i. Medical College of Wisconsin, Student Health Services.

The applicant must: **1). Return the original complete form to MATC, Nursing Center, Room M240.** **Name**_____
2). Retain a copy to show instructor.

Program_____

MILWAUKEE AREA TECHNICAL COLLEGE
Health Occupations Division

RELEASE FORM: HEPATITIS B

1

Please read thoroughly and check the appropriate box.

☐ I have received and read the information regarding Hepatitis B and the vaccines that are available.

As a student, 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. I have been advised to be vaccinated with Hepatitis B vaccine. 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 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 pursue the vaccination series.

I hereby release Milwaukee Area Technical College, its Board Members, and personnel, and any clinical facility at which I train from any liability for any consequences to me or any claims arising out of or related to my decision to be or not to be vaccinated. I hereby agree to indemnify all of the above persons and organizations for any and all claims, including the attorneys' fees and costs, which may be brought against any one of them by anyone claiming to have been injured as a result of any injury which may occur as a result of my decision.

OR

☐ I do not wish to decline the Hepatitis B vaccine. I am currently in the process/or have completed the series. I under

_____

☐ Student signature required Signature of Student Date

2

Return this form to the Health Center as soon as possible with any information listed. Please have authorized medical signature <u>if</u> you have had any dosages.

<u>IF HBV given:</u>

1st Dose Date: _____ _____
Authorized Medical Signature

2nd Dose Date: _____ _____
Authorized Medical Signature

3rd Dose Date: _____ _____
Authorized Medical Signature

<u>Please Return this Form to:</u>
MATC Health Center (Room M240)
700 West State Street
Milwaukee WI 53233