COLLEGE OF THE SEQUOIAS FIRE ACADEMY

FIRE ACADEMY RECRUIT MEDICAL EVALUATION

INSTRUCTIONS

Each prospective Firefighter Academy Cadet must receive medical clearance to participate in the Academy. Both the Physical and Mental Stress Job Description and this Firefighter Medical Evaluation form must be reviewed and considered by your physician during the medical clearance evaluation. Take both documents to your physician!

This CONFIDENTIAL Medical Questionnaire is to be completed and taken to your physician, NOT the College of the Sequoias.

Following a review of this Medical Questionnaire and the Physical and Mental Stress Job Description, your physician may or may not require additional medical evaluation.

Following your evaluation, your physician must complete PAGE ONE of this document. You must then submit ONLY PAGE ONE to the Fire Academy Coordinator. Do not submit the other pages of this document to the College!

COLLEGE OF THE SEQUOIAS FIRE ACADEMY

FIRE ACADEMY CADET MEDICAL CLEARANCE

This page must be completed by your physician and submitted to the Fire Academy Coordinator! Do not return pages 2 thru 5 to the College!

Print Cadet Candidate Name:
Print Personal Physician Name:
Physician's Statement I understand that the above named Cadet Candidate intends to participate in the College of the Sequoias Firefighter Academy. He or she will be required to participate in arduous physical training, a physical fitness program, and wear a tight-fitting self-contained breathing apparatus, all without physical limitation. I have reviewed the College of the Sequoias Physical and Mental Stress Job Description and the Firefighter Recruit Medical Evaluation form completed by this individual. I have conducted an appropriate physical examination and (check one): ☐ Recommend this candidate be allowed to participate in the Academy ☐ Do NOT recommend this candidate be allowed to participate in the Academy

Physician's Signature:	Date:

Remarks:

Can you read? ☐ Yes ☐ No	Today's date:
Part A. Section 1. Mandatory - The following information must be provided by every employee who has been selected to use any type of respirator, including Self-Contained Breathing Apparatus. PLEASE PRINT.	
Your name:	
Your age (to nearest year):	Sex: ☐ Male ☐ Female
Your height: _____ ft. _____ in.	Your weight: _____ lbs.
Telephone numbers where you can be reached by the health care professional who reviews this questionnaire: Daytime: ( )	Evening: ( )
List your current occupation or occupations: _____ _____ _____	
List previous occupations for the past 10 years: _____ _____ _____	
List your current and previous hobbies: _____ _____ _____	

Part A. Section 2. Every employee who has been selected to use any type of respirator, including Self-Contained Breathing Apparatus, must answer 1 through 15 below (please check "YES" or "NO").		
	YES	**NO**
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?		
2. Have you ever had any of the following conditions?		
a. Seizures (fits)		
b. Diabetes (sugar disease)		
c. Allergic reactions that interfere with your breathing		
d. Claustrophobia (fear of closed-in places)		
e. Trouble smelling odors		
3. Have you ever had any of the following pulmonary or lung problems?		
a. Asbestosis		
b. Asthma		
c. Chronic bronchitis		
d. Emphysema		
e. Pneumonia		
f. Tuberculosis		
g. Silicosis		
h. Pneumothorax (collapsed lung)		
i. Lung cancer		
j. Broken ribs		
k. Any chest injuries or surgeries		
l. Any other lung problem that you've been told about		
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath		
b. Shortness of breath when walking fast on level ground or walking up a slight hill		
c. Shortness of breath when walking with others at an ordinary pace on level ground		
d. Have to stop for breath when walking at your own pace on level ground		
e. Shortness of breath when washing or dressing yourself		
f. Shortness of breath that interferes with your job		
g. Coughing that produces phlegm (thick sputum)		
h. Coughing that wakes you early in the morning		
i. Coughing that occurs mostly when you are lying down		
j. Coughing up blood in the last month		
k. Wheezing		
l. Wheezing that interferes with your job		
m. Chest pain when you breathe deeply		
n. Any other symptoms that you think may be related to lung problems		
5. Have you ever had any of the following cardiovascular or heart problems?		
a. Heart attack		
b. Stroke		
c. Angina		
d. Heart failure		
e. Swelling in your legs or feet (not caused by walking)		
f. Heart arrhythmia (heart beating irregularly)		
g. High blood pressure		
h. Any other heart problem that you've been told about		

Part A. Section 2. - continued		
	YES	**NO**
6. Have you ever had any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest		
b. Pain or tightness in your chest during physical activity		
c. Pain or tightness in your chest that interferes with your job		
d. In the past two years, have you noticed your heart skipping or missing a beat		
e. Heartburn or indigestion that is not related to eating		
f. Any other symptoms that you think may be related to heart or circulation problems		
7. Do you currently take medication for any of the following problems?		
a. Breathing or lung problems		
b. Heart trouble		
c. Blood pressure		
d. Seizures (fits)		
8. If you've used a respirator, (SCBA) have you had any of the following problems? (If you've NEVER used a respirator, check here ☐ and go to question 9.)		
a. Eye irritation		
b. Skin allergies or rashes		
c. Anxiety		
d. General weakness or fatigue		
e. Any other problem that interferes with your use of a respirator		
9. Would you like to talk to the health care professional who will review questionnaire about your answers? If "yes", give daytime phone number: (____)_____		
10. Have you ever lost vision in either eye (temporarily or permanently)?		
11. Do you currently have any of the following vision problems?		
a. Wear contact lenses		
b. Wear glasses		
c. Color blind		
d. Any other problems with eyes or vision		
12. Have you ever had an injury to your ears, including a broken eardrum?		
13. Do you currently have any of the following hearing problems?		
a. Difficulty hearing		
b. Wear a hearing aid		
c. Any other hearing or ear problem		
14. Have you ever had a back injury?		
15. Do you currently have any of the following musculoskeletal problems?		
a. Weakness in any of your arms, hands, legs, or feet		
b. Back pain		
c. Difficulty fully moving your arms and legs		
d. Pain or stiffness when you lean forward or backward at the waist		
e. Difficulty fully moving your head up or down		
f. Difficulty fully moving your head side to side		
g. Difficulty bending at your knees		
h. Difficulty squatting to the ground		
i. Climbing a flight of stairs or a ladder carrying more than 25 lbs.		
j. Any other muscle or skeletal problem that interferes with using a respirator		

Part B. - Please mark "YES" or "NO", and provide additional information as requested.		
	YES	**NO**
1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen?		
If "yes", do you have feelings of dizziness, shortness of breath, pounding in your chest or other symptoms when you're working under these conditions?		
2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust)? If "yes", name the chemicals, if you know them:		
3. Have you ever worked with any of the materials, or under any of the conditions, listed below?		
a. Asbestos		
b. Silica (e.g., in sandblasting/Porcelain manufacture)		
c. Tungsten/cobalt (e.g., grinding or welding this material)		
d. Beryllium		
e. Aluminum		
f. Coal (for example, mining)		
g. Iron (e.g., foundry work)		
h. Tin		
i. Any other hazardous exposures? If "yes", describe these exposures:		
4. Have you been in the military services?		
If "yes", were you exposed to biological or chemical agents in training or combat?		
5. Have you ever worked on a HAZMAT team?		
6. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter medications)? If "yes", name the medications, if you know them:		