

Perth County Paramedic Services
EMPLOYEE HEALTH STATUS REPORT COMMUNICABLE DISEASE - 2017

This is to certify, _____ has been immunized against
(Employee Name – print clearly)

the listed diseases in Table 1 – Part A of the Ministry of Health and Long Term Care – Ambulance Service Communicable Disease Standards, Version 2, or, such immunization is **medically contraindicated**, or, there is **laboratory evidence of immunity**, or, there is **medically documented diagnosis or verification of history**.

If multiple vaccinations are necessary please indicate the dates for each vaccination

TABLE 1 - PART A		
<u>Disease</u>	<u>Schedule</u>	<u>Date(s)</u>
Tetanus Diphtheria	Primary series (3 doses) if unimmunized Td booster doses every 10 years.	
Pertussis	1 single dose of tetanus diphtheria acellular pertussis (Tdap) vaccine regardless of age if not previously received in adulthood.	
Polio	Primary series (3 doses) if previously unimmunized or unknown polio immunization history.	
Varicella (Chickenpox)	2 doses if no evidence of immunity.	
Measles	2 doses if no evidence of immunity regardless of age.	
Rubella	1 single dose if no evidence of immunity.	
Mumps	2 doses if no evidence of immunity.	
Hepatitis B	2 – 4 age appropriate doses with serologic testing within 1 to 6 months after completing the series. Please include the dates for each vaccination and date of serology test	

List exceptions to immunization:

Physician's Name (Printed)

Physician's Signature

Date (MM/DD/YY)

This form complies with the conditions of the *Ambulance Act*, Ontario Regulation 257/00, Part III of the Regulations (Qualifications of EMA's and Paramedics) Section 6 article (h), which states an EMA and/or a Paramedic employed by an ambulance service must hold a valid certificate signed by a physician that states that the person is immunized against diseases listed in Table I to the document entitled Ambulance Service Communicable Disease Standards, published by the Ministry, as that document may be amended from time to time, or that such immunization is contra-indicated.



Perth County Paramedic Services Health Questionnaire

The information collected in this form is solely for the purpose of obtaining information required under the Ambulance Act and is a condition of employment. This information will only be used by the County of Perth and will not be released to other agencies.

This area for Applicant Completion:

Name: _____

Sex: Male Female

Date of Birth _____
(y/m/d)

Address: _____

City: _____ Province _____

Postal Code _____

Telephone Number: (_____) _____

Alternate Number (_____) _____

Email: _____

Applicant's Certificate and Release of Information

I certify that the foregoing information is to the best of my knowledge correct and I agree to this report and any future report derived from this information being given only to Perth County Paramedic Service. The fee for the completion of this form is the sole responsibility of the applicant and not the responsibility of the County of Perth.

Applicant's Signature: _____

Date: _____



Perth County Paramedic Services Health Questionnaire

The following 7 pages are for Physician Completion only:

Applicants First Name: _____

Last Name: _____

Health History:

To be completed by the examining Physician. Yes answers must be explained below in the space provided.

1. Diseases of the Senses (Deafness, Vertigo, Visual Deficiencies, etc.) Yes No
2. Cardiovascular Disease (Heart Failure, Angina, Infarction, Embolism, Arrhythmia, Syncope, Surgery, etc.) Yes No
3. Respiratory Diseases (Asthma, Chronic Bronchitis, Emphysema, etc.) Yes No
4. Disease of the Musculo-Skeletal System (Fracture(s) or Amputation, Arthritis, etc.) Yes No
5. Metabolic Diseases (Diabetes (+) (-), Hypoglycemia, Thyroid, etc.) Yes No
6. Psychiatric Disorders/ Mental Health (PTSD, Psychoneurosis, Psychosis, etc.) Yes No
7. Addiction (Alcohol, Sedatives, Tranquilizers, Narcotics, etc.) Yes No
8. Other Diseases (Blackouts, Fainting Spells, Anemia, Cancer, Blood Dyscrasia, etc.) Yes No
9. Neurological Diseases (Seizures, Cerebrovascular Disease, Parkinson's disease, Multiple Sclerosis, Dementia, Head Injury, Mental Retardation, etc.) Yes No

Date of First Seizure: _____

Date of Last Seizure: _____

History Details (include degree of decompensation, etc.)



Perth County Paramedic Services Health Questionnaire

Medications (including details of all medication prescribed and dosages)

Medical Examination:

Date of Examination: _____

Height: _____

Weight: _____

1. Eyes: R.E. L.E.

Without Glasses 20/ 20/

With Glasses 20/ 20/

Horizontal Field of Vision Right Normal Restricted

Left Normal Restricted

Squint, disease or eye injury: _____

Indicate type of test given: Snellen Other: _____

2. Hearing: Meets standards defined in the H.T.A. with or without a hearing aid. Yes No

3. Heart: Apical Rate: _____ Rhythm: _____

Murmurs: _____ Blood Pressure: _____

4. Locomotion: Upper Extremities: _____ Lower Extremities: _____

Neck & Lumbar: _____

5. Chest & Abdomen: _____

6. Urinary: Urine Protein _____ Glucose _____

7. Diabetes: Yes * No Type: _____

*Treatment: Diet Alone: Oral Medication (amount per 24hrs.) _____

Insulin (amount per 24 hrs.) _____



Perth County Paramedic Services Health Questionnaire

8. Hypoglycemia: Frequency: _____
 Circumstances: _____
 Loss of Consciousness: _____
 Decrease in Cognition, etc.: _____

9. Neurological: Gait & Stance: _____ Reflexes: _____
 Tremor: _____ Coordination: _____

10. Mental Competence: _____ Judgement: _____

11. Evidence of Emotional Disorder:

Instability Yes No
 Neurosis Yes No
 Alcoholism Yes No

Psychosis Yes No
 Drug Habituation Yes No

Immunization Record:

1. Tuberculin Skin Test

Negative or Unknown Reaction: 2 step Test required prior to employment (within 3 months of hire date). *Must be completed before MMR vaccine (or any live attenuated vaccine) is given or 30 days after receiving a live attenuated vaccine.*

If step 1 is negative (0-9 mm. induration at 48-72 hours), do Step 2 in 7-21 days.

If either step 1 or 2 is positive (10 mm. Or more in duration @ 48-72 hours) evaluate as in A above.

	Date of Test	Dates Read	Induration (mm.) + -
STEP 1			
STEP 2			

If over one year since last Mantoux please give and document below

Mantoux: Date given _____ Date read _____

Result: _____ mm induration



Perth County Paramedic Services Health Questionnaire

Known Positive Reaction:

Date of TB Test: _____ Size (mm): _____
(y/m/d)

- Evaluation: 1. Physical examination/symptom enquiry regarding evidence of active disease
2. Chest X-ray: Date: _____ Result: _____ (copy of x-ray report *within 1 year*)
3. INH Prophylaxis: No Yes Dosage _____
Duration _____

2. Chicken Pox (Varicella)*: Immunization Date: _____

***Laboratory evidence of immunity is required (attach copy of Lab report)**

Immune YES NO

3. Tetanus: (every 10 years) Immunization Date: _____

4. Diphtheria: (every 10 years) Immunization Date: _____

5. Polio: (Full Primary Series is required) Immunization Date: _____ series was completed

OR

Date: _____ of last booster

6. Measles, Mumps, and Rubella*: Immunization Date: _____

***Laboratory evidence of immunity is required for each disease, Red Measles, Mumps and Rubella. (Attach lab reports.)**

7. Pertussis: Immunization Date: _____
(y/m/d)

8. Hepatitis B Vaccine*: Date 1st _____ Date 2nd _____ Date 3rd _____

***Laboratory evidence of immunity is required Attach copy of Lab Report**

9. Influenza: Date: _____ (Must be current year)
(y/m/d)



Perth County Paramedic Services Health Questionnaire

If immunizations not complete, an explanation is required:

***Yellow Immunization cards will not be accepted as proof of immunization.**

Health Status Report – Communicable Diseases

This report is being requested in order to comply with the conditions of Ambulance Services Communicable Disease Standards which states each paramedic within the service is to be free from all communicable diseases as listed below. This form is to be completed by your general practitioner.

Taken from Ministry of Health and Long Term Care Emergency Services Branch, Ambulance Services Communicable Disease Standards Table 1 – Part B April 2000 (Revised October 2002).

This is to certify that _____ (Patient's full name)

To the best of my knowledge IS FREE FROM the following communicable diseases listed below / next page :



Perth County Paramedic Services Health Questionnaire

	Free From	NOT Free From		Free From	NOT Free From
Acquired Immunodeficiency Syndrome (AIDS)			Measles		
Amebiasis			Menigitis, acute, i. bacterial		
Anthrax			ii. viral		
Botulism			iii. other		
Brucellosis			Meningococcal disease, invasive		
Campylobacter enteritis			Malaria		
Chancroid			Mumps		
Chicken Pox (Varicella)			Ophthalmia Neonatorum		
Chlamydia trachomatis infections			Parathyphoid Fever		
Cholera			Pertussis (Whooping Cough)		
Cytomegalovirus Infection (Congenital)			Plague		
Diphtheria			Poliomyelitis (Acute)		
Encephalitis (Primary Viral)			Psittacosis/Ornithosis		
Food Poisoning, all causes			Q Fever		
Gastroenteritis			Rabies		
Giardiasis			Rubella		
Gonorrhea			Rubella (Congenital Syndrome)		
Group A Streptococcal Disease (invasive)			Salmonellosis		
Haemophilus influenza B Disease (Invasive)			Shigellosis		
Hemorrhagic Fevers including Ebola virus disease, Marburg Virus Disease, and other virual causes			Syphilis		
Viral Hepatitis including Hepatitis A, B, C and D (Delta Hepatitis)			Trichinosis		
Influenza			Tuberculosis		
Lassa Fever			Tularemia		
Legionellosis			Typhoid Fever		
Leprosy			Verotoxin producing E.Coli Infections		
Listeriosis			Yellow Fever		
Lyme Disease			Yersiniosis		

Notes (if applicable)



Perth County Paramedic Services Health Questionnaire

Applicant Name: _____

Physician's Name: _____

Physician's Address: _____

Family Physician or Certified Specialist in _____

How long has this person been your patient? _____

Based on today's examination, there are no medical or physical reasons that would prevent this person from safely fulfilling the duties of a paramedic in the province of Ontario.

Physicians Name _____

Physicians Signature _____