

**Prerequisite Medical Requirements for EMT Students**

Welcome and thank you for your interest in the UCLA Center for Prehospital Care EMT Program! This information is provided to help you meet the documentation and medical requirements for the EMT program. These requirements are developed by the Department of Health and Human Services and Centers for Disease Control and Prevention. In addition to needing the below medical requirements is for your EMT program, our clinical/field affiliates will require the same immunizations in order for you to participate in their program.

**Medical Services**

Your physician’s office should be able to provide everything you need to complete your EMT program prerequisites. Physician’s offices and pharmacies (such as CVS) that have walk up services may also be able to complete the health requirements. For other locations in Los Angeles County please visit the Department of Health Services web site at: [www.ladhs.org/clinics/](http://www.ladhs.org/clinics/).

**Name:** \_\_\_\_\_ **Student ID:** \_\_\_\_\_ **Course #:** \_\_\_\_\_

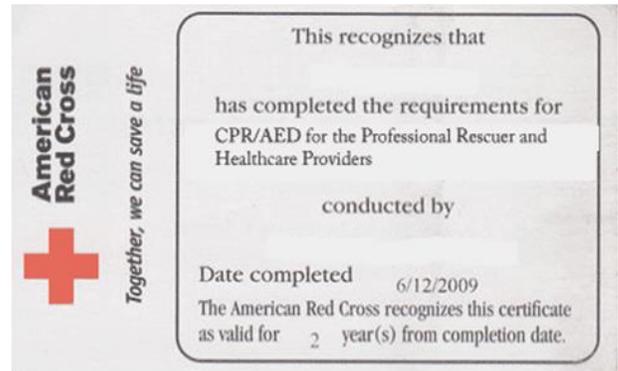
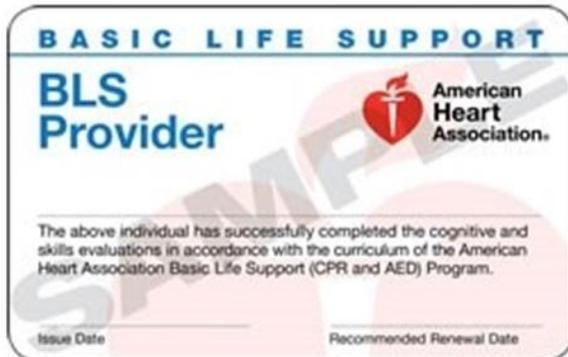
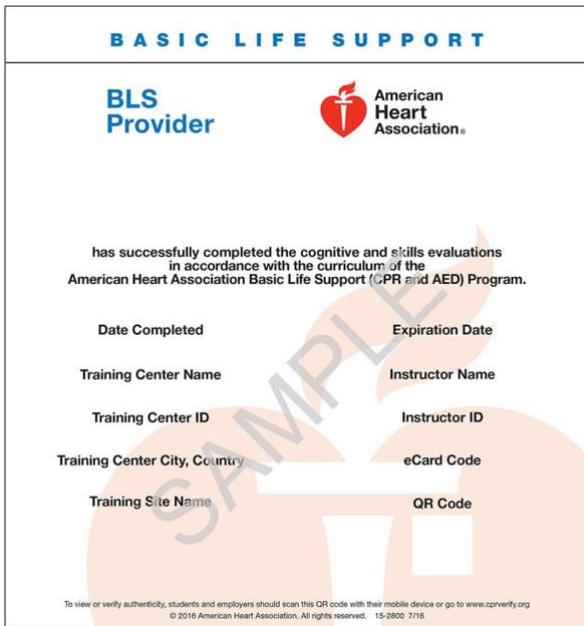
The following items are required to complete the ride along portion of the EMT course. The ride alongs must be completed within 30 days of the end of the course so it is important to complete this documentation as soon as possible. When complete bring this form with you and turn it in to the program coordinator. Please clearly denote the required vaccinations if you are including multiple health forms.

<b>Student Requirements</b>	<b>Coordinator Initials (for office use)</b>
1. Copy of a current American Heart Association or American Red Cross Basic Life Support for Healthcare Provider card (signed-copy front and back of card).	
2. Proof of health insurance coverage including private insurer, or state provided insurance, or federal provided insurance (copy front and back of card).	
3. Proof of Hepatitis B Vaccine or refusal as demonstrated on the Hepatitis Verification Form.	
4. Completion of the Flu Vaccine Requirement form.	
5. Proof of current Measles/Mumps/Rubella (MMR) immunization or titer.	
6. Proof of current Tetanus/Diphtheria/Pertussis (Tdap) immunization or titer.	
7. Proof of current varicella (chicken pox or VZV) immunization, or titer, or a signed and dated note from a physician indicating you have had the chicken pox.	
8. Proof of negative TB skin test (within 3 months), or Quantiferon-Gold blood test (within 3 months), or a negative chest x-ray (within 2 years).	
9. Original Physical and Mask Fit Clearance form, found in this packet, stamped or signed and dated from a physician within 6 months prior to the start of class specifying that you can participate in the clinical portion of the EMT program without physical limitations.	
10. Proof of COVID19 Vaccination. While the vaccine may not be required for your specific course, if you have received vaccination, please include a copy.	

### CPR Course Requirements

Below are examples of what your Basic Life Support CPR for Healthcare Provider Card should look like from the American Heart Associate or the American Red Cross. Only basic life support for the healthcare provider from the American Heath Association or American Red Cross will be accepted. Please include a copy, front and back of your CPR card with this prerequisite packet.

If you do not have the basic life support certification, you can complete the course at UCLA. You can sign up for any of our [online BLS courses](https://www.cpc.mednet.ucla.edu/emt-bls) (https://www.cpc.mednet.ucla.edu/emt-bls), complete the online course work, and bring your online course completion certificate to EMT class for the official skills verification. Following skill verification, you will then receive your American Heart Association Basic Life Support Certification.



### Hepatitis B Vaccine Verification

Please select one of the following:

- I have completed the entire series (3) of Hepatitis B vaccinations (please submit documentation verifying completion of 3-shot series).
- I have a positive titer for Hepatitis B virus (please submit documentation verifying titer).
- I have started the 3-shot series (please include documentation to indicate receiving the first shot).

I understand that due to my participation as a student in the UCLA EMT Course, I may be at risk for exposure to blood or potentially infectious materials and acquiring the Hepatitis B Virus (HBV) infection. I have been asked to be vaccinated with the Hepatitis B vaccine. However, I decline the 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 obtain the vaccination series and will submit documentation of such to the Program while I am enrolled as a student. I decline the Hepatitis B Vaccination Series due to one of the following reason(s):

- I am declining because I choose not to have the Hepatitis B vaccination series. I am aware that I may change my mind at a later date.
- I have already completed the entire series of 3 Hepatitis B vaccinations. I do not have a record I received the vaccinations.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

UCLA Center for Prehospital Care  
Department

### Flu Vaccine Verification

For the period of November 1<sup>st</sup> to March 31<sup>st</sup>, UCLA EMT students must be in compliance with the Los Angeles County Public Health order for all persons in patient care areas to either have the flu vaccine or wear a mask. I understand that due to my participation in ride alongs as a student in the UCLA EMT Program during any time from November 1<sup>st</sup> to March 31<sup>st</sup>, I have been asked to be vaccinated against the flu. This timeline is based on the Los County Department of Public Health and is subject to change or extension.

Please select one of the following:

- I have already received a flu vaccination for the current period listed above (please submit documentation verifying the vaccination).
  
- I am declining because I choose not to have the flu vaccination. I understand that in order to be exempt I must have the [University of California Medical Exemption Request Form](#)\* completed and submitted with this form. I understand that without the vaccine, I am required to wear a mask while in contact with patients or working in patient care areas during my ride alongs and internships for the program. This includes patient rooms, exam room, emergency department bay areas, etc. I understand that by declining the vaccine, I continue to be at risk of acquiring the flu. I am aware that I may change my mind about the vaccine at a later date. I can obtain the flu vaccination in the future while enrolled as a student and will then submit the documentation to the program.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

UCLA Center for Prehospital Care  
Department

\* The University of California Medical Exemption Request Form can be found at:  
<https://www.immunizationrequirement.ucla.edu/Portals/98/pdfs/Medical%20Exemption%20Request%20Form%202018.pdf>

**Medical Evaluation Questionnaire for OSHA Respirator/Mask Fit Testing**

This questionnaire is to help your physician determine whether you can perform the mask fit (respirator) test which will be conducted in class. The evaluation must be repeated if you have a physical change (e.g., significant weight change) in between the original evaluation and the start of class. We encourage you to obtain this clearance at the same time you do your physical. Completing the Mask Fit Testing in class requires men to shave their facial hair as it may prohibit a mask (respirator) from fitting properly. If you are not agreeable to shaving your facial hair, see your program's "details" website page for an alternative to using the mask.



**Questionnaire directions for students:**

1. Complete the questionnaire.
2. Give the questionnaire and form to your physician or authorized healthcare provider for review/evaluation.
3. The physician will retain the questionnaire for your medical file, and will return the physical & mask fit clearance form.

You are required to confirm that you can read (circle one): Yes / No

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Your age (to nearest year): \_\_\_\_\_ Sex: Male/Female

Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs. Your title: Student Phone Number \_\_\_\_\_

Check the type of respirator you will use (you can check more than one category):

- a.  N, R, or P disposable respirator (filter-mask, non-cartridge type only).  
*(Note: requires men to shave facial hair, e.g., beard or stubble.)*
- b. \_\_\_\_\_ Other type (e.g., half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

Have you worn a respirator (circle one): Yes/No, If "yes," what type(s): \_\_\_\_\_

**Section 2. (Mandatory) Questions 1 through 9 below must be answered by every student who has been selected to use any type of respirator (please CIRCLE "yes" or "no" for your answers). Your physician or authorized healthcare provider should ask the student these questions to determine eligibility and retain this answer sheet for their medical files.**

1. Do you currently smoke tobacco, or have you smoked tobacco in the last month: Yes/No
2. Have you ever had any of the following conditions?
  - a. Seizures (fits): Yes/No
  - b. Diabetes: Yes/No
  - c. Allergic reactions that interfere with your breathing: Yes/No
  - d. Claustrophobia (fear of closed-in places): Yes/No
  - e. Trouble smelling odors: Yes/No
3. Have you ever had any of the following pulmonary or lung problems?
  - a. Asbestosis: Yes/No
  - b. Asthma: Yes/No
  - c. Chronic bronchitis: Yes/No
  - d. Emphysema: Yes/No
  - e. Pneumonia: Yes/No
  - f. Tuberculosis: Yes/No
  - g. Silicosis: Yes/No
  - h. Pneumothorax (collapsed lung): Yes/No
  - i. Lung cancer: Yes/No
  - j. Broken ribs: Yes/No
  - k. Any chest injuries or surgeries: Yes/No
  - l. Any other lung problem that you've been told about: Yes/No

4. Do you currently have any of the following symptoms of pulmonary or lung illness?
  - a. Shortness of breath: Yes/No
  - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
  - c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
  - d. Have to stop for breath when walking at your own pace on level ground: Yes/No
  - e. Shortness of breath when washing or dressing yourself: Yes/No
  - f. Shortness of breath that interferes with your job: Yes/No
  - g. Coughing that produces phlegm (thick sputum): Yes/No
  - h. Coughing that wakes you early in the morning: Yes/No
  - i. Coughing that occurs mostly when you are lying down: Yes/No
  - j. Coughing up blood in the last month: Yes/No
  - k. Wheezing: Yes/No
  - l. Wheezing that interferes with your job: Yes/No
  - m. Chest pain when you breathe deeply: Yes/No
  - n. Any other symptoms that you think may be related to lung problems: Yes/No
  
5. Have you ever had any of the following cardiovascular or heart problems?
  - a. Heart attack: Yes/No
  - b. Stroke: Yes/No
  - c. Angina: Yes/No
  - d. Heart failure: Yes/No
  - e. Swelling in your legs or feet (not caused by walking): Yes/No
  - f. Heart arrhythmia (heart beating irregularly): Yes/No
  - g. High blood pressure: Yes/No
  - h. Any other heart problem that you've been told about: Yes/No
  
6. Have you ever had any of the following cardiovascular or heart symptoms?
  - a. Frequent pain or tightness in your chest: Yes/No
  - b. Pain or tightness in your chest during physical activity: Yes/No
  - c. Pain or tightness in your chest that interferes with your job: Yes/No
  - d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
  - e. Heartburn or indigestion that is not related to eating: Yes/No
  - f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No
  
7. Do you currently take medication for any of the following problems?
  - a. Breathing or lung problems: Yes/No
  - b. Heart trouble: Yes/No
  - c. Blood pressure: Yes/No
  - d. Seizures (fits): Yes/No
  
8. If you've used a respirator, have you ever had any of the following problems? (If you've never used a respirator, check the following space and go to question 9)
  - a. Eye irritation: Yes/No
  - b. Skin allergies or rashes: Yes/No
  - c. Anxiety: Yes/No
  - d. General weakness or fatigue: Yes/No
  - e. Any other problem that interferes with your use of a respirator: Yes/No
  
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to these questions? Yes/No

**Physical & Mask Fit Testing Clearance Form**  
(To be completed by physician or authorized provider)

Student Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Physical Requirements for EMT Students**

Physical demands on EMT Students: Aptitudes required for work of this nature are good physical stamina, endurance, and body condition that would not be adversely affected by frequently having to walk, stand, lift, carry, and balance at times. Hand-eye and motor coordination is necessary. The work can involve light lifting (from 10 to 20 pounds maximum) to very heavy lifting (50 pounds frequently, no maximum) and can involve climbing, balancing, stooping, kneeling, crouching, crawling, reaching, handling, fingering, feeling, talking, hearing, and seeing.

- Please check this box if the above-named student is medically clear to participate in the skills and clinical portions of the EMT program as outlined above. This includes the student being medically clear to participate in the mask fit testing for the EMT program without limitations.**

Printed name of provider: \_\_\_\_\_

Provider's signature: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

**Please affix  
provider's stamp in  
this area for  
verification. A  
medical ID number is  
also acceptable:**

If there are limitations, please list them here:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The original of this page must to be turned into EMT Program Coordinator.  
Photocopies of this form will not be accepted.