HLT1762 EMT COURSE STUDENT REQUIREMENTS FORMS PACKET

Allied Health Department

MINERAL AREA COLLEGE

P.O. Box 1000 | Park Hills, MO 63601 | 573.431.4593

MINERAL AREA COLLEGE

Dear Prospective EMT Student,

The course HLT1762 for Emergency Medical Technician is rigorous. In addition to the indicated classroom hours, students are required to complete additional hours in simulation and laboratory, clinical (hospital), field internship (ambulance) and other mandatory trainings. The EMT course schedule does not conform to the Mineral Area College academic calendar. The class schedule may include mornings, evenings, weekends, holidays or times when the campus is otherwise closed. Furthermore, there are no excused absences in HLT1762. Please note, students absent the first day of class will be dropped from registration.

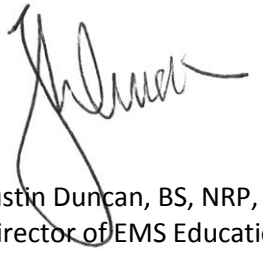
Furthermore, EMT students must meet the following criteria for the clinical and field components of the program. These requirements are mandatory by the clinical facilities. Please see the attached forms for more information. These requirements must complete by the first day of class or by the date designated. No EMT student will be admitted to any clinical facility unless these requirements are met. Students will be dropped from course registration for failure to comply with these requirements. Any necessary healthcare costs are the responsibility of the student.

In addition to the requirements outlined on the following page, EMT students are required to obtain CPR certification in Basic Life Support for Healthcare Providers through the American Heart Association. This will be completed as a class and more information will be provided the first day of class.

Also, EMT students are responsible to purchase specified uniforms from the approved vendor. Please see the attached order form. A list of other required supplies and equipment will be provided the first day of class. The cost of uniforms and supplies are the responsibility of the student.

Please keep copies of physical exam and immunizations for your records. You will need these documents in the future when applying for employment positions. It is not the responsibility of the Allied Health Department to provide or copy these records for current or previous students.

If you have any questions, please contact the Allied Health Department office at (573) 518-2172.
Sincerely,



Justin Duncan, BS, NRP, CCEMT-P, FP-C
Director of EMS Education

Enclosures

HLT1762 REQUIREMENTS CHECKLIST
EMS Education | Allied Health Department | Mineral Area College

Students enrolled in HLT1762 must meet the following criteria and submit documentation (i.e. shot record, laboratory report) in order to obtain clearance to participate in clinical, field and internship experiences. These requirements are due to the Allied Health Department office ***no later than the first day of class***.

❑ **Identification and Residency**
Must bring driver's license, social security card and birth certificate to the Allied Health Department office to be scanned into student file. Driver's license must be valid and address must match student address on file. A headshot photo (selfie) with neutral background must be emailed to plewis@mineralarea.edu.

❑ **Health Inventory and Physical Evaluation Form**
Must be completed and signed by licensed medical professional (i.e. NP, DO, MD).

❑ **Measles, Mumps, Rubella (MMR) Vaccine or**
Must provide immunization record that validate administration of **two (2) doses**, or laboratory report validating positive titer. Negative titer results will require one or two booster doses. If two doses are required, they must be separated by 28 days. Documented proof of vaccines or titers must be attached.

❑ **Varicella (Chickenpox) Vaccine or Titer**
Must provide documentation of **two (2) doses**, or laboratory documentation of positive titer. Negative titer will require one or two booster doses. If two doses are required, they must be separated by 28 days. Documented proof of vaccines or titer must be attached.

❑ **Hepatitis B Vaccine, Titer or Declination**
Must provide immunization record validating completion of a **three (3) dose** vaccine series, or laboratory report validating positive titer, or signed and dated Hepatitis B Medical Exemption Statement. Documented proof of vaccines, titer or contraindication/precaution must be attached.

❑ **Tetanus, Diphtheria, Pertussis (TDAP) Vaccine**
Must provide immunization record validating received after the age of eleven (11) **AND** no earlier than ten (10) years prior to course completion date. Otherwise, if these criteria are not indicated then a booster is required.

❑ **Two-Step Tuberculin Skin Test (PPD)** *and chest x-ray if applicable*
Must obtain a two-step PPD and provide proof of negative results. *The first PPD should be obtained two weeks prior to the first day of class in order to have sufficient time for both tests by deadline*. Following the first PPD, results should be read 48-72 hours later. One week after the reading of the first PPD, the second test should be obtained then read again 48-72 hours later. Students with a current or previous positive PPD are required to provide the results of a chest x-ray and prescribed treatment.

❑ **Background Check and Drug Screening**
Must successfully pass a background check and drug screening *by the designated date* at approved facility only. More details will be provided the first day of class.

❑ **Influenza Vaccine**
Must provide proof of vaccine (i.e. pharmacy prescription and receipt) *by the designated date*. More details will be provided the first day of class.

❑ **Uniform Order Form**
Completed form must be submitted *the first day of class*. Exact cash or money order must be attached to order form. No personal checks accepted.

Please note, the student is responsible for the costs incurred to complete requirements.

IMMUNIZATION VERIFICATION FORM
Allied Health Department | Mineral Area College

Program: ❑ Nursing ❑ Paramedic ❑ EMT ❑ Radiology

➔ Take this form with you to your physical exam and have your licensed medical professional complete it.
➔ Do not return the form to us until all vaccine doses or titers are complete.
➔ You must **ATTACH DOCUMENTED PROOF** of vaccines and/or titers (i.e. shot records, lab results).

Student First and Last Name: _____ Student ID#: _____

Measles, Mumps, Rubella (MMR)

1st Dose: _____ 2nd Dose: _____ **—OR—**

Measles Titer Value: _____ Date: _____ Immune Positive: ❑ Yes ❑ No

Mumps Titer Value: _____ Date: _____ Immune Positive: ❑ Yes ❑ No

Rubella Titer Value: _____ Date: _____ Immune Positive: ❑ Yes ❑ No

Varicella (Chickenpox) Vaccine

1st Dose: _____ 2nd Dose: _____

—OR— Titer Value: _____ Date: _____ Immune Positive: ❑ Yes ❑ No

Hepatitis B Vaccine

1st Dose: _____ 2nd Dose: _____ 3rd Dose: _____

—OR— Titer Value: _____ Date: _____ Immune Positive: ❑ Yes ❑ No

—OR— Request and submit Hepatitis B Medical Exemption Statement
You must attach document proof of medically diagnosed contraindication or precaution!

Tetanus/Diphtheria/Pertussis (TDAP)
*Must not be earlier than May 31, 2010 and must be completed **after** the age of 11.*

Last Booster Date: _____ ❑ Less than 10yrs since shot ❑ Completed after the age of 11

Medical Professional Credentials

_____ _____ _____
Medical Professional Signature Title Date

_____ _____ _____
Medical Professional Printed Name Facility Name Phone Number

★ATTACH COPY OF SHOT RECORD AND/OR TITER LABORATORY RESULTS ★

TUBERCULOSIS QUESTIONNAIRE
Allied Health Department | Mineral Area College

Program: ❑ Nursing ❑ Paramedic ❑ EMT ❑ Radiology

Date Form Completed: _____ / _____ / _____ Social Security Number: _____ / _____ / _____ Age: _____

_____ Country of Birth: _____
Last Name First Name Middle Initial or Date Entered U.S.: _____ / _____ / _____

	UNKNOWN	NO	YES	DATE
Have you ever had a vaccine to prevent tuberculosis (BCG)?				
Have you ever had a positive/reactive TB skin test?				
Have you ever been told you have TB?				
Have you ever been treated for either active or latent TB?				
Have you ever had a chest x-ray which showed tuberculosis?				
Have you ever had a TB skin test?				
Do you have any chronic illnesses?				
Have you ever been diagnosed with or treated for cancer?				
Have you ever been diagnosed with AIDS or tested positive for HIV?				
Have you ever used injectable drugs or shared needles with anyone?				
Do you take any medication that makes your immune system weak?				
Has a health practitioner told you that your immune system isn't working right or can't fight infections?				
Have you ever lived with someone known to have active TB?				
Have you received any vaccination in the past four (4) weeks?				
Do you have allergies to latex, medications or any vaccine?				
Have you ever lost your balance or fainted from a blood draw?				

Do you have any of the following symptoms?	NO	YES
Chest pain		
Cough that has lasted for 3 weeks or longer		
Coughing up blood		
Fever		
Loss of appetite		
Unexplained weight loss		
Night sweats		
Chronic lung problems		
Chronic kidney disease or dialysis		
Diabetes		

Last TB Skin Test

Date: _____ / _____ / _____ Results: ❑ Positive ❑ Negative ❑ Unknown

If positive, what medication did you take?
❑ INH ❑ Pyrazinamide (PZA) ❑ Rifampin ❑ Ethambutol ❑ None ❑ Other: _____

_____ _____
Student Signature Date

TUBERCULOSIS VERIFICATION FORM
Allied Health Department | Mineral Area College

Program: ❑ Nursing ❑ Paramedic ❑ EMT ❑ Radiology

➔ Complete your TB tests between the specified dates ONLY:
➔ This form must be completed by a medical professional; Do not return the form until all steps are complete.
➔ You must attach documented proof of testing, and chest x-ray and treatment if applicable

Student First and Last Name: _____ Student ID#: _____

1ST STEP

Date Applied: _____ Arm: ❑ Left ❑ Right Lot#: _____ Exp: _____

Administered By *(please print name)*: _____ Signature: _____

Date Read: _____ Results (mm): _____ ❑ Positive ❑ Negative

Facility Name: _____ Phone: _____

Read By *(please print name)*: _____ Signature: _____

Facility Name: _____ Phone: _____

Results must be read 48-72 hours following administration.
Second tuberculin skin test must be administered 7 days after Step 1 is READ!

2ND STEP

Date Applied: _____ Arm: ❑ Left ❑ Right Lot#: _____ Exp: _____

Administered By *(please print name)*: _____ Signature: _____

Date Read: _____ Results (mm): _____ ❑ Positive ❑ Negative

Facility Name: _____ Phone: _____

Read By *(please print name)*: _____ Signature: _____

Facility Name: _____ Phone: _____

CHEST X-RAY – Students who have a positive TB test must provide a chest x-ray

Date: _____ Results: ❑ Positive ❑ Negative

Medical Treatment Plan: _____

Student: ❑ can ❑ cannot participate in providing patient care in all clinical areas.

_____	_____	_____
Medical Professional Signature	Title	Date
_____	_____	_____
Medical Professional Printed Name	Facility Name	Phone Number

HEALTH INVENTORY AND PHYSICAL EVALUATION FORM
Allied Health Department | Mineral Area College

Program: ❑ Nursing ❑ Paramedic ❑ EMT ❑ Radiology

➔ This form must be completed and signed by a medical professional.
➔ Please note, the results of this inventory/evaluation does not affect selection in the Allied Health program.
➔ Reasonable accommodations will be made in the Allied Health programs for students with special needs.

Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Urinalysis (Optional): ❑ Normal ❑ Other: _____ Date: _____ / _____ / _____

Blood Work (Optional): ❑ Normal ❑ Other: _____ Date: _____ / _____ / _____

Vision: OD _____ OS _____ OU _____ Corrected: ❑ Yes ❑ No

General Appearance

Skin	❑ Normal	❑ Abnormal	Heart	❑ Normal	❑ Abnormal
Lymphatic	❑ Normal	❑ Abnormal	Vascular System	❑ Normal	❑ Abnormal
Head, Face, Neck	❑ Normal	❑ Abnormal	Abdomen and Viscera	❑ Normal	❑ Abnormal
Ears and Hearing	❑ Normal	❑ Abnormal	Breasts	❑ Normal	❑ Abnormal
Nose and Sinus	❑ Normal	❑ Abnormal	Endocrine System	❑ Normal	❑ Abnormal
Mouth and Throat	❑ Normal	❑ Abnormal	Spine	❑ Normal	❑ Abnormal
Teeth and Gingiva	❑ Normal	❑ Abnormal	Neurologic	❑ Normal	❑ Abnormal
Lungs, Chest	❑ Normal	❑ Abnormal	Musculoskeletal	❑ Normal	❑ Abnormal

❑ Yes ❑ No **Sufficient eyesight** to observe patients, read patient records, manipulate equipment and accessories, visually monitor patients in dimmed light via video monitors, evaluate radiographs for quality, and see distinct colors on sonograms.

❑ Yes ❑ No **Sufficient hearing** to communicate with patients and other members of the health care team, monitor patients via audio monitors, and hear background sounds during equipment operations.

❑ Yes ❑ No **Satisfactory speaking, reading, listening and writing skills** to effectively and promptly communicate in English.

❑ Yes ❑ No **Sufficient gross and fine motor coordination** to manipulate equipment and accessories, lift and to stoop, bend or promptly assist patients who become unstable.

❑ Yes ❑ No **Satisfactory physical strength and endurance** to move immobile patients to or from a stretcher or wheelchair to the x-ray table, work with arms extended overhead, stand in place for long periods of time.

❑ Yes ❑ No **Satisfactory intellectual and emotional functions** to ensure patient safety and exercise independent judgment and discretion in the performance of assigned responsibilities.

Is there evidence of current misuse of illicit drugs or alcohol: ❑ Yes ❑ No

Student First and Last Name: _____ Student ID#: _____

Recommendation for physical activity: ❑ Unlimited ❑ Limited Explain: _____

_____

_____

Does student have any permanent disabilities: ❑ Yes ❑ No List restrictions: _____

_____

_____

Explain any abnormalities indicated above: _____

_____

_____

_____

The patient is under treatment for the following medical conditions: _____

_____

_____

_____

Itemize all medication patient is taking (name, dosage and frequency): _____

_____

_____

_____

List all allergies patient has: _____

_____

List of injuries and/or operations: _____

_____

_____ _____

Medical Professional Signature Date

_____ _____

Medical Professional Printed Name Medical Professional Title

_____ _____

Facility Name Facility Phone Number

UNIFORM ORDER FORM
EMS Education | Allied Health Department

MINERAL AREA COLLEGE

Name: _____

Email: _____ Phone: _____

Item	Description	Cost	Size	Quantity	Subtotal
	Polo Shirt: Men's or Women's	S - XL: $26			
		2XL: $28			
		3XL: $29			
	Sweatshirt	S - XL: $20			
		2XL: $25			
		3XL: $26			
	Hoodie	S - XL: $23			
		2XL: $25			
		3XL: $26			
	Zip-up Hoodie	S - XL: $30			
		2XL: $32			
		3XL: $33			
	Hat: Velcro Back	$10			
	Hat: Flex Fit	S/M & L/XL: $13			
	Other:				
				TOTAL $	

Please note, unapproved apparel will not be embroidered without prior authorization.

BZB Embroidery
120 W. Pine Street
Farmington, Missouri 63640
Phone: (573) 756-7570

ATTACHED PAYMENT IN FORM OF EXACT CASH OR MONEY ORDER (NO PERSONAL CHECKS)