TYLER JUNIOR COLLEGE™

Student Immunization Record
Emergency Medical Services Programs – EMT and Paramedic

Last Name	First Name	Middle	
Street Address	**City**	**State**	**Zip**
Phone	**Date of Birth**	**sex**	**Social Security Number / A#**

Required Immunizations

Tetanus/Diptheria (Tdap)
You must have at least one dose within the last ten years.

Date of Last Dose _____/_____/_____
month day year

Measles
Students born before January 1, 1957 must have two doses since 2 months of age. Doses must be 30 days apart.

Date of Last Dose _____/_____/_____
month day year

Mumps
Students born since January 1, 1957 must have had at least one dose since 12 months of age

Date of Last Dose _____/_____/_____
month day year

Rubella
At least once dose since 12 months of age is required

Date of Last Dose _____/_____/_____
month day year

Tuberculosis (TB)
Current within one year of class start

Date of Last Dose _____/_____/_____
+ or - month day year

Hepatitis B
Complete series or proof of immunity by the start of clinical rotations

Initial Dose _____/_____/_____
month day year

Second Dose _____/_____/_____
month day year

Third Dose _____/_____/_____
month day year

Varicella
Two doses required if initiated after 13 years of age

Date of Last Dose _____/_____/_____
month day year

Bacterial Meningitis
Proof of vaccination or booster during the five (5) years preceding and at least ten (10) days prior to enrollment.

MCV4_____
MPSV_____

_____/_____/_____
Date of Last Dose month day year

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Proof of Immunity

Texas Education Code 2.09
Certification of measles illness, rubella or mumps illness. Section 97.63 of this title, 'Required Immunizations," states that physician validated histories of measles and mumps are acceptable in lieu of vaccine. All histories of measles or mumps illness must be supported by a written statement from a physician licensed to practice medicine in the United States. The physician's statement should contain wording such as "this is to verify" that (name of student) had measles or mumps illness on or about (month, day and year and does not need a measles or mumps vaccine". A copy of the statement must be attached to the student's immunization record and the original should be returned to the student. If a student is unable to submit a physician's statement, then the vaccine is required. **A PHYSICIAN'S STATEMENT OF RUBELLA I LLNESS WITHOUT SEROLOGICAL DOCUMENTATION WILL NOT SUBSTITUTE FOR THE RUBELLA VACCINE**. All serological evidence of measles, mumps and rubella illnesses must consist of a written statement from a physician licensed to practice medicine in the United States or a laboratory report indicating confirmation of the disease (a titer).

Texas Department of Health Rule 97.61-97.72 states that students who elect to not acquire the Hepatitis B series must sign a waiver. Students who sign the waiver must understand that acceptance into the clinical setting is subject to the approval of the clinical affiliate not Tyler Junior College or the Tyler Junior College EMSP Faculty or Staff.

Signature of Physician or Practitioner Date

Address City State Zip

Student Immunization Record
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Last Name	First Name	Middle Initial	Preferred Name
Address – Number and Street	**City**	**State**	**Zip Code**
Phone Number	**Date of Birth**		**A#/Social Security #**

Health Science Program (check one): ☐ Emergency Medical Technician Basic **OR** Paramedic **Term: _____**

To the examining physician/practitioner: Please complete the following health evaluation report.
Emergency Medical Services Programs (EMSP) is the department within the College of Professional and Technical Programs responsible for educating, training and preparing students to obtain a license as an Emergency Medical Technician or Paramedic and to deliver pre hospital emergency care in a variety of situations. When EMSP accepts a student, it is understood that the individual can meet the demands, duties and responsibilities listed below.

General Duty Requirements:
The general environmental conditions in which emergency medical service personnel work includes, but is not limited to, a variety of hot and cold temperatures and, at times, they may be exposed to hazardous fumes. They may be required to walk, climb, crawl, bend, pull, push or life and balance over less than ideal terrain. They can also be exposed to a variety of noise levels, which can be quite high, particularly when sirens are sounding. The individual must be able to function effectively in uncontrolled environments with high levels of ambient noise. Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely affected by having to lift, move, carry and balance while moving or transporting in excess of 200 pounds (specifically, 250 pounds, single person, power grip stance, weight lifted off the ground and not above the waist during agility testing). Motor coordination is dexterity to bandage, splint, and move patients as well as tasks including properly applying invasive airways and administering intravenous therapy and injections.

Additionally, other essential body and mental function the individual should have include the visual acuity to drive in a safe manner, accurately discern street names, map read and the ability to distinguish house numbers, differentiate between medication labels and packaging as well as appropriate dosing of medications. Use of communication devices for transmitting patient information, and responding to physician's advice is also essential. The ability to concisely and accurately describe verbally to health professionals the patient's condition is critical. The student/provider must also be able to accurately summarize all data in the form of a written report.

In your opinion, does this individual have any mental and/or physical conditions or issues preventing the performance of the essential requirements of the Emergency Medical Services Programs? If yes, please explain on the reverse side of this form. Attach supplemental information if necessary.

I, _____ have performed a physical examination of the person above.
PLEASE PRINT NAME

_____ **Phone No: _____ Date: _____**
Physician's Signature

Address: _____
Street **City** **State** **Zip Code**

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If, in your opinion, an individual has any mental and/or physical conditions or issues preventing the performance of the essential requirements of the Emergency Medical Services Programs please explain below:

Additional forms or documentation attached? YES ☐ NO ☐

Additional follow up required / requested YES ☐ NO ☐ if *YES*, Please explain below:

Physician's Signature **Printed Name**

Date **Phone Number**