



North Idaho College

Workforce Training Center

Fire Fighter I Academy

1. APPLICANT INFORMATION: please print

Name _____

Address _____

City _____ State _____ Zip _____ Birthdate _____

Phone (primary) _____ (other) _____

Male / Female

E-mail _____

2. REQUIRED ATTACHMENTS:

_____ Completed Medical Clearance form

_____ Immunization Record or Immunization Waiver

Signature _____ Date _____

Return completed forms to:

NIC Workforce Training Center

525 S Clearwater Loop, Post Falls ID 83854 phone (208) 769-3333



North Idaho College

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Fire Fighter I Academy

MEDICAL CLEARANCE

TO PERFORM PHYSICAL DUTIES WHILE TRAINING

DOCTOR: Prior to releasing, please read and complete this form.

(PLEASE PRINT APPLICANT'S NAME)

Students training in Fire Fighter I Academy are required to be mentally alert and maintain sufficient flexibility, strength and endurance to perform a variety of labor intensive and demanding skills activities involving fire/rescue situations. Normal skills training activities may be illustrated by the following:

1. Climbing ladders and stairs and performing tasks from heights.
2. Lifting patients and transporting patients on gurneys or stretchers.
3. Using heavy tools and heavy lifting from awkward positions
4. Being exposed to extreme heat and cold environments.
5. Wearing self-contained breathing apparatus (SCBA) while performing physical work.

Is the current condition of this individual such that he/she is in physical condition to perform the training responsibilities defined, in part, above?

Yes _____ No _____

_____ Date _____

Doctor's Signature

Please type or print Doctor's full name _____

Address _____

Telephone _____

Fire Fighter I Academy

IMMUNIZATION RECORD

Please Print Legibly

Name _____

Last Name

First Name

Middle Name

Phone Number

Permanent Address _____

Street

City

State

Zip Code

Date of Birth ____/____/____

Student Last 4 digits of Social Security _____

To be completed and signed by your health care provider or please attach official immunization record.

RECOMMENDED IMMUNIZATIONS:

Tetanus-Diphtheria (Primary series with DTaP or DTP and booster with Td in the last ten years)

1. Primary series of four doses with DtaP or DTP:

#1 ____/____ #2 ____/____ #3 ____/____ #4 ____/____

M Y

M Y

M Y

M Y

2. Tetanus-Diphtheria (Td) booster within the last ten years..... ____/____

M

Y

HEPATITIS B (Three doses of vaccine or a positive Hepatitis surface antibody)

1. Immunization

a. Dose #1 ____/____ b. Dose #2 ____/____ c. Dose #3 ____/____ or

M Y

M Y

M Y

2. Hepatitis B surface antibody (titer should only be drawn after vaccine series or exposure)

Date ____/____ Result Reactive _____ Non-reactive _____

M Y

Tuberculosis Skin Test: Date: ____/____/____ **Result:** _____

(Example: PPD, tine)

If positive PPD, when was your Chest X-ray? **Date:** ____/____/____ **Result:** _____

Health Care Provider

Name _____ Address _____

Signature _____ Phone _____

Immunization Waiver

Due to medical, religious, or personal reasons, I choose to decline immunization.

Student name (printed) _____

Student signature: _____ Date: _____

Please return form to:

NIC Workforce Training Center, 525 S Clearwater Loop, Post Falls, ID 83854

Telephone Number: (208)769-3333 Fax Number: (208) 769-769-3223