



# North Idaho College

***Workforce Training Center***

## Fire Fighter I Academy

**APPLICANT INFORMATION: please print**

Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Birthdate \_\_\_\_\_

Phone (primary) \_\_\_\_\_ (other) \_\_\_\_\_

Male / Female

E-mail \_\_\_\_\_

**REQUIRED ATTACHMENTS:**

Completed Medical Clearance form  
 Immunization Record or Immunization Waiver

Signature \_\_\_\_\_ Date \_\_\_\_\_

*Return completed forms to:*

NIC Workforce Training Center  
Health Careers and Emergency Services  
525 South Clearwater Loop, Post Falls ID 83854  
Phone (208) 769-3333



# 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:

Climbing ladders and stairs and performing tasks from heights.

Lifting patients and transporting patients on gurneys or stretchers.

### Using heavy tools and heavy lifting from awkward positions

Being exposed to extreme heat and cold environments.

Wearing self-contained breathing apparatus (SCBA) while performing physical work.

In your evaluation, does this individual, by history or physical exam, have any current condition that may prevent or limit this person from participating in the activities listed above? Are they in adequate physical condition to perform these training activities? If not, please identify. Please advise if any further testing is recommended.

Yes  No  Comments (optional)

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)

Primary series of four doses with DtaP or DTP:

#1 \_\_\_\_\_ / \_\_\_\_\_ #2 \_\_\_\_\_ / \_\_\_\_\_ #3 \_\_\_\_\_ / \_\_\_\_\_ #4 \_\_\_\_\_ / \_\_\_\_\_ M Y M  
Y M Y M

Tetanus-Diphtheria (Td) booster within the last ten years \_\_\_\_\_ / \_\_\_\_\_

M Y

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

Immunization

a. Dose #1 \_\_\_\_\_ / \_\_\_\_\_ b. Dose #2 \_\_\_\_\_ / \_\_\_\_\_ c. Dose #3 \_\_\_\_\_ / \_\_\_\_\_  
\_\_\_\_\_ or M Y M Y M Y

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 South Clearwater Loop, Post Falls, ID 83854 Telephone Number: (208)769-3333 Fax Number: (208) 769-769-3223