Kentville Volunteer Fire Department

This can be filled out by your Doctor or

by the Fire Department Doctor Dr. Chris King 902-365-7120

Medical Clearance for Evaluation

Applicant Name: _____

The medical clearance for evaluation as a member of the Kentville Volunteer Fire Department is set out to ensure applicants are able to proceed with physical evaluation testing and eventually firefighting.

In evaluating applicants, the medical doctor conducting the evaluation is to be aware that the bona fide health requirements to be a firefighter are agility, aerobic capability and strength.

Testing will be carried out in full Bunker Gear including helmet, coat, pants, boots, flash hood, gloves and breathing apparatus. The breathing apparatus weighs approximately 50 lbs. The applicant will not be required to breathe from the breathing apparatus but must wear it.

Firefighting demands strength, power, agility and endurance. Applicants will be required to demonstrate reasonable capability in performance of a series of tasks associated with firefighting.

Verification of Medical Information

Is this individual taking any medications that could affect normal physical response to exercise or firefighting?

Yes_____ No_____ If Yes, please explain

Is there any pre- existing medical condition that would interfere with the individual's ability to participate in the physical evaluation or fire fighting? Yes_____ No____

Is there any medical reason that this individual should not undertake strenuous exercise or fire fighting?

Yes____ No____

The Medical Doctor assessing the individual should make all physical examinations believed to be necessary in order to reasonably determine the individual's ability to carry out the physical testing described here-in.

KENTVILLE VOLUNTEER FIRE DEPARTMENT RECRUIT EVALUATION

PART 1: Patient consent for physician to report medical information

Name:_____ Date of birth: _____

Address: _____

_____ Postal code_____

Telephone: Home _____

Cellular_____

I authorize any physician, hospital or medical clinic to release to the department any information regarding my medical condition:

_____ _____
Patient signature Date

PART 2: Vision (with or without visual correction)

YES	NO	
___	___	Is visual acuity at least 20/40 (6/12) in better eye?
___	___	Is field of vision at least 120 degrees with both eyes open & examined together?
___	___	Visual field defect (If “yes,” please explain) _____
		_____
___	___	Is visual correction required for driving?
___	___	Diplopia
___	___	Diseases, injury, or defect of the eye? (If “yes,” please explain)
		_____
		_____
___	___	Does the patient meet the vision standards to perform as a firefighter?

PART 3: Medical history and physical examination

A – Alcohol abuse

YES NO

___ ___ Clinical diagnosis of alcoholism?

___ ___ If ‘Yes,” is the problem under control?

___ ___ If ‘Yes,” how long has control been maintained? _____

B – Drug usage

___ ___ Clinical diagnosis of drug addiction?

___ ___ Is applicant taking any drugs that would cause impairment of firefighting duties?

___ ___ If “Yes,” please state drug(s) name and dosage _____

_____

_____

C – Respiratory diseases

YES NO

___ ___ Does applicant have evidence of severe respiratory impairment?

D – Peripheral vascular diseases

Is there current history of evidence of:

YES NO

___ ___ Peripheral arterial vascular disease

___ ___ Disease of the veins

Please comment _____

D – Peripheral vascular diseases (cont)

Is there current history of evidence of:

YES NO

___ ___ Cerebrovascular accidents including TIAs

If “yes,” date of event: _____

___ ___ Cerebral aneurysm

___ ___ If “yes,” has patient undergone surgical treatment?

If yes, date of surgery _____

E – Hearing loss

YES NO

___ ___ Any significant degree of hearing loss?

If “yes,” please explain _____

F – Renal disease

YES NO

___ ___ Is there a history of kidney disease?

G -- Musculoskeletal disabilities

YES NO

___ ___ Evidence of musculoskeletal condition such as amputation, arthritis, disease of the spine, etc. likely to impair the ability to perform as a firefighter?

If “yes,” please explain _____

H – Metabolic diseases

YES NO

___ ___ Diagnosis of diabetes mellitus?

If “yes,” how is control maintained?

____Diet ___Oral medication ___Insulin-treated

___ ___ Is condition well-controlled?

J -- Stability

YES NO

___ ___ Is candidate prepared for witnessing, and capable of dealing with, severe human trauma? (eg: motor vehicle collision, fire victims, etc.)

K – Psychiatric disorders

YES NO

___ ___ Current history or evidence of an emotional disorder?

___ ___ Current history or evidence of a personality disorder manifesting in anti-social, erratic or aggressive behaviour?

___ ___ If “yes,” is judgement impaired sufficiently to affect abilities and interaction?

___ ___ Current history or evidence of a psychotic illness?

___ ___ If “yes,” is judgement impaired sufficiently to affect abilities?

L – Diseases of the nervous system

YES NO

___ ___ Diagnosed with cognitive impairment?

___ ___ Single, unexplained episiode of syncope (unexplained loss of consciousness)?

If “yes,” date of episode: _____

___ ___ Episodes of recurrent syncope?

If “yes,” please enclose neurological and cardiovascular assessments.

___ ___ Has applicant ever had a seizure?

___ ___ If “yes,” was this a case of an unprovoked seizure?

Date of episiode _____

___ ___ Has applicant been diagnosed with epilepsy?

If “yes,” date of the most recent seizure? _____

___ ___ Medication required to maintain seizure control?

___ ___ Progressive disorder? Of coordination and muscle control (eg. Parkinson's, disease,multiple sclerosis, amytrophic lateral sclerosis)

If "yes, please provide information on degree and severity of disability.)_____
_____

___ ___ Stable deficit (e.g. Paralysis, nerve damage?

If "yes, please provide information on degree and severity of disability.)_____

_____

___ ___ Vestibular disorder?

If "yes," please explain_____

M – Cardiovascular diseases

Current history or evidence of:

YES NO

___ ___ Coronary artery disease

___ ___ Coronary artery bypass surgery

If "yes," date of surgery: _____

___ ___ Myocardial infarction, unstable angina?

If "yes," date of last attack: _____.

___ ___ Uncontrolled hypertension

___ ___ Congestive heart failure

___ ___ Cardiac arrythmia?

___ ___ Valvularheart disease

___ ___ Artificial cardiac pacemaker

PART 4: Medical fitness as a KVFD candidate

Date of medical examination: _____

My recommendation(s) as a result of this examination are:

_____ Candidate is fit to join the Kentville Volunteer Fire Department

_____Canddiate is fit to join the Kentville Volunteer Fire Department with the following restrictions:

_____

_____

_____

_____Canddiate is unfit to join the Kentville Volunteer Fire Department.

Enclose any reports or comments you feel are appropriate.

Physician's name_____

Address: _____

_____

Telephone: _____

_____
Physician's signature