





Last Name: \_\_\_\_\_ First Initial: \_\_\_\_\_ M.I.: \_\_\_\_\_

Recruit No. \_\_\_\_\_  
(Office Only)

**Recruit Medical Information**  
*To Be Completed by Recruit*

**Medications:** All physician prescribed and over the counter medications must be declared

*List Medications (prescribed or over the counter) you are currently taking*

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

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Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Reason: \_\_\_\_\_

Yes  No Does your physician(s) know that you are participating in a High Intensity exercise program specific to firefighter training?

Yes  No Have you had any previous orthopedic injuries, surgeries or therapy that would limit or prevent you from fully participating in the Physical Fitness and/or Practical Skills Training.

Please describe any reasons and limitations: \_\_\_\_\_

**Health History:** Do you now or have you had in the past:

- Yes  No History of heart problems, chest pain, or stroke
- Yes  No Increased blood pressure
- Yes  No Any chronic illness or condition
- Yes  No Difficulty with exercise
- Yes  No Advice from a physician not to exercise
- Yes  No Recent surgery (within the past 12 months)
- Yes  No Pregnancy (now or within the past 3 months)
- Yes  No History of breathing or lung related problems
- Yes  No Muscle, joint, or back disorder, or any previous injury still affecting you
- Yes  No Diabetes or thyroid disorder
- Yes  No Smoke tobacco (within the last 12 months)
- Yes  No Obesity (greater than 20% over ideal body weight)
- Yes  No Been told you have high cholesterol levels
- Yes  No Hernia or any other condition that may be aggravated by lifting weights
- Yes  No History of heart or coronary artery disease or stroke in any members of your immediate family

Please explain any "yes" answers: \_\_\_\_\_

The Medical Information is strictly used for the Safety and Welfare of the Recruit.



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**Allergies**  
*To Be Completed by Recruit*

**Allergies - Food:** *Please list any known allergies to foods*

**Symptoms:**

If a food allergen has been ingested, but *no symptoms*:

Mouth - Itching, tingling, or swelling of lips, tongue, and/or mouth:

Skin - Hives, itchy rash, swelling of the face or extremities:

Gut - Itching, tingling, or swelling of lips, tongue, and/or mouth:

Throat ⊕ - Tightening of throat, hoarseness, hacking cough:

Lung ⊕ - Shortness of breath, repetitive coughing, wheezing:

Heart ⊕ - Weak or thread pulse, low blood pressure, fainting, pale, blueness:

Other ⊕ - \_\_\_\_\_:

If reaction is progressing (several of the above areas affected), give:

⊕ - Potentially Life Threatening. The severity of symptoms can quickly change

**Give Checked Medication**

To be determined by Physician  
Authorizing treatment

Epinephrine  Antihistamine

The recruit possesses and can administer his own treatment of  Epinephrine  Antihistamine

**Allergies - Medication:** *Please list any known allergies to medications*

Symptoms: \_\_\_\_\_

**Allergies – Environment/Other:** *Please list any known allergies to environment or other*

Symptoms: \_\_\_\_\_



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## **Emergency Contact Information**

*To Be Completed by Recruit*

Please list the names, addresses and phone numbers of 2 (two) individuals (i.e. spouse, relatives) and your Physician to be contacted in the event of a medical emergency or serious injury.

### **Emergency Contact:**

1. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Mailing Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ Zip: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Mailing Address: \_\_\_\_\_

City / Town: \_\_\_\_\_ Zip: \_\_\_\_\_

### **Physicians Contact:**

Name: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Practice Name: \_\_\_\_\_

City / Town: \_\_\_\_\_ Zip: \_\_\_\_\_



Recruit No.

**Medical Demographic Card**

FD: \_\_\_\_\_, City/Town: \_\_\_\_\_ Date Updated: \_\_\_ / \_\_\_

**Recruit Name:** \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Home Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

Town/City: \_\_\_\_\_ State: CT, \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Height: \_\_\_ ' \_\_\_ " Weight: \_\_\_\_\_ lbs.

**Medical History:**  None; \_\_\_\_\_, \_\_\_\_\_

**Allergies to Medicines:**  None; \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

**Prescribed Medications:**  None; \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

**Over the Counter Medications:**  None; \_\_\_\_\_, \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Relation:  Spouse  Parent  Other; \_\_\_\_\_

Emergency Phone Numbers: Home Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Cut Here

(for Physical Training Copies, Reduce Original 65%)

Cut Here



Recruit No.

**Medical Demographic Card**

FD: \_\_\_\_\_, City/Town: \_\_\_\_\_ Date Updated: \_\_\_ / \_\_\_

**Recruit Name:** \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_ / \_\_\_ / \_\_\_

Home Address: \_\_\_\_\_ Apt.: \_\_\_\_\_

Town/City: \_\_\_\_\_ State: CT, \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Height: \_\_\_ ' \_\_\_ " Weight: \_\_\_\_\_ lbs.

**Medical History:**  None; \_\_\_\_\_, \_\_\_\_\_

**Allergies to Medicines:**  None; \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

**Prescribed Medications:**  None; \_\_\_\_\_, \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_

**Over the Counter Medications:**  None; \_\_\_\_\_, \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_ Relation:  Spouse  Parent  Other; \_\_\_\_\_

Emergency Phone Numbers: Home Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_



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**Authorization for Release of Performance Information**  
*To Be Completed by Recruit*

I, \_\_\_\_\_, a Recruit Firefighter at the Connecticut Fire Academy, give permission to Recruit Firefighter Program Manager and/or designee of the Recruit Firefighter Program to release all information related to my performance during the Recruit Firefighter Program. This information includes but is not limited to Recruit Performance Evaluations and documents described in the Recruit Firefighter Program’s Rules & Regulations. This authorization limits the release of information to the recruits’ current sponsoring Fire Department’s Fire Chief and/or designee, and to any/all fire service related inquires initialed below.

Signature: \_\_\_\_\_  
(Recruit Applicant) Date

The following section applies to Recruit Firefighters sponsored by a Fire Department but who are not considered a career firefighter or an employee of that Fire Department (self-pays).

**Authorization for Release of Contact Information**  
*To Be Completed by (Self-Pay) Recruits*

I, \_\_\_\_\_, a Recruit Firefighter at the Connecticut Fire Academy, give permission to Recruit Firefighter Program Manager and/or designee of the Recruit Firefighter Program to release my Contact Information to any/all Fire Departments soliciting for potential candidates.

Signature: \_\_\_\_\_  
(Recruit Applicant) Date

- Release of Performance Information Documentation to **ANY/ALL** fire service related inquires.

Recruit Initials: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_



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**Emergency Medical Training**  
*To Be Completed by Recruit*

The recruit applicant is required to have current Emergency Medical Training or attend the Recruit Firefighter Program's scheduled American Heart Association BLS for Healthcare Provider CPR/AED and Heartsaver First Aid classes during the program. Recruit applicants with expiring CPR/AED or First Aid cards will be offered those scheduled classes as a refresher/recertification.

A copy of EMS Training Cards, Certification or License is required on the first day.

EMS Training:

EMT/P     EMT/I     EMT     EMR     other \_\_\_\_\_

Your Name as Appears on Card: \_\_\_\_\_ Exp. Date: \_\_\_/\_\_\_/\_\_\_

NO EMS Training; the recruit does not have proof of current EMS related training or completion of Basic First Aid course.

CPR/AED issued from:

American Red Cross

American Heart Association

Other: \_\_\_\_\_

Your Name as Appears on Card: \_\_\_\_\_ Exp. Date: \_\_\_/\_\_\_/\_\_\_

Expired/ Expiring EMS Training; the recruit has an expired or expiring Basic First Aid and/or CPR/AED course certificate.





## **First Day of Class – Reporting Procedure**

- Start Time:** 08:00, *Students should plan on arriving early*
- Reporting In:** Students report to the Cafeteria for Sign in. If you enter from the rear parking lot, follow the sidewalk to a glass door in a breezeway between the two major structures. Take a left up the ramp, Cafeteria is on the Left.
- Student Parking:** Students Vehicles will be parked behind the Administration Building in the designated area, furthest from the building to allow more space for daily traffic parking.
- Traffic Cones with signage will be displayed for First Day arrivals to assist with directions for parking.
- Required Documents:** Prepare Recruit Application – Section 2 documents for collection on day 1:
- PAGE 1 – Recruit Personal Information Form
  - PAGE 2 – Recruit Medical Information Form
  - PAGE 3 – Allergies
  - PAGE 4 – Emergency Contact Information
  - PAGE 5 – Medical Demographic Cards
  - PAGE 6 – Authorization for Release of Performance Information Form
  - PAGE 6 – Authorization for Release of Contact Information Form (*Self-Pays Only*)
  - PAGE 7 – Emergency Medical Training
  - PAGE 8 – Fire Academy and Fire Department Mission Statements
  - Copy of CPAT (Candidate Physical Ability Test) Certification
  - Copy of EMS training Certification/License (EMR/EMT/EMT/P)
  - Copy of CPR/AED Certification