



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

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

**Healthcare Provider Information**  
*To Be Completed by Fire Department Staff*

In the event of a medical emergency requiring advance level of care, the Connecticut Fire Academy uses the Bradley International Airport Fire Department Paramedics for R-5 coverage and either the Windsor Locks, Suffield or East Granby Ambulance as the R-2 provider.

For “routine” medical emergencies or evaluations, the Suffield Medical Associates Walk-In Clinic is normally used, with a CVS Pharmacy conveniently located in the adjacent plaza to the Suffield Medical Associates for prescriptions etc.

Please Check with your “Risk Management” officer or Worker’s Compensation provider if this not their desired provider for this location of the state.

*If required*, please provide the information for the nearest recommended Healthcare provider to the Connecticut Fire Academy. If possible we will make every attempt to see your recruit(s) use the listed provider if needed.

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

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

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



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(Office Only)

**Fire, Live Fire, and Flashover Survival Training**  
*To Be Completed by Fire Department Staff*

As the Chief of the \_\_\_\_\_ Fire Department, I hereby authorize the above applicant to participate in Fire Training, Live Fire and Flashover Simulator Training and experience, and therefore understand that the above mentioned member will be covered by my department's worker's compensation insurance while participating in such training, and the Commission on Fire Prevention and Control, its commissioners, officers, agents or employees shall not be held liable for any injuries sustained during such training. The applicant is considered by my department's standards to be physically and emotionally fit to perform firefighting evolutions without special consideration, and where applicable, to meet CFR 1910.134, regulation for the use of respirators.

I further understand that the Commission on Fire Prevention and Control, its commissioners, officers, agents or employees shall not be held liable for damage to the above mentioned member's protective clothing and equipment while participating in Fire Training, Live Fire and Flashover Simulator training.

I understand that during Recruit and Live Fire Training, and while properly wearing prescribed Structural Firefighting Personal Protective and other clothing, there is the risk of personal injury not limited to abrasion, contusion, laceration, thermal and/or steam burn(s).

Signature: \_\_\_\_\_  
(Chief of Department)

\_\_\_\_\_ Date

Chief's Name: \_\_\_\_\_  
Please Print

Recruit Signature: \_\_\_\_\_





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

**Medications:** All physician prescribed medications must be declared

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

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

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

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

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

Yes  No Have you had a physical in the past 12 months?

Yes  No Does your physicians know that you are participating in an exercise program?

Please describe any physical activity that you do somewhat regularly: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**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.  
Information provided will be destroyed at the conclusion of the Program.



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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

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> Antihistamine |
| <input type="checkbox"/> Epinephrine | <input type="checkbox"/> 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 three individuals (i.e. spouse, relatives) to be contacted in the event of a medical emergency or serious injury.

**Emergency Contact:** Name: \_\_\_\_\_ Relation: \_\_\_\_\_

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

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

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

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

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

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

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

**Physicians Contact:** Name: \_\_\_\_\_

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

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

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



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# Medical Demographic Card

To Be Completed by Recruit

Please Complete all Four Cards

The Medical Information is strictly used for the Safety and Welfare of the Recruit. Information provided will be destroyed at the conclusion of the Program.

<b>Recruit Medical Information</b>
Recruit # _____ FD: _____ Date: _____
Recruit Name: _____ Age: _____
Date of Birth: ___ / ___ / ___ Height: ___' ___" Weight: _____ lbs.
PMH: <input type="checkbox"/> None: _____
Allergies: <input type="checkbox"/> None: _____
Meds: <input type="checkbox"/> None: _____
Contact Info: _____ Relation: _____
(H) _____ (C) _____ (W) _____
<b>Physical Training Copy</b>
<b>Recruit Medical Information</b>
Recruit # _____ FD: _____ Date: _____
Recruit Name: _____ Age: _____
Date of Birth: ___ / ___ / ___ Height: ___' ___" Weight: _____ lbs.
PMH: <input type="checkbox"/> None: _____
Allergies: <input type="checkbox"/> None: _____
Meds: <input type="checkbox"/> None: _____
Contact Info: _____ Relation: _____
(H) _____ (C) _____ (W) _____
<b>Physical Training Office Copy</b>
<b>Recruit Medical Information</b>
Recruit # _____ FD: _____ Date: _____
Recruit Name: _____ Age: _____
Date of Birth: ___ / ___ / ___ Height: ___' ___" Weight: _____ lbs.
PMH: <input type="checkbox"/> None: _____
Allergies: <input type="checkbox"/> None: _____
Meds: <input type="checkbox"/> None: _____
Contact Info: _____ Relation: _____
(H) _____ (C) _____ (W) _____
<b>Safety Officer Copy</b>
<b>Recruit Medical Information</b>
Recruit # _____ FD: _____ Date: _____
Recruit Name: _____ Age: _____
Date of Birth: ___ / ___ / ___ Height: ___' ___" Weight: _____ lbs.
PMH: <input type="checkbox"/> None: _____
Allergies: <input type="checkbox"/> None: _____
Meds: <input type="checkbox"/> None: _____
Contact Info: _____ Relation: _____
(H) _____ (C) _____ (W) _____
<b>Duty Officer Copy</b>



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**Authorization for Release of Grades**  
*To Be Completed by Recruit*

I, \_\_\_\_\_, a Recruit Firefighter at the Connecticut Fire Academy, give permission to Recruit Firefighter Program Coordinators of the Recruit Firefighter Program to release all Quiz Scores, Homework Grades and Test Scores that are part of my Recruit Progress reports, and my final Certification Test Scores, to my Fire Department's Fire Chief and/or designee.

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

\_\_\_\_\_ Date



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

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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 first day.

EMS Training:     EMT/P     EMT/I     EMT     EMR     other \_\_\_\_\_

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: \_\_\_\_\_

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.