The Department of Emergency Services and Public Protection
The Connecticut Fire Academy

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

Recruit Personal Information

To Be Completed by Recruit

EDUCATION:

Please check the highest level completed

□ G.E.D. □ High School Graduate Attended College: □1 □2 □ 3 □4

Please list any type of Degree(s) received along with the Major or Minor course of study

□AS □BS □AA □BA □Master's Degree: _____
Minor Course of Study: _____

□AS □BS □AA □BA □Master's Degree: _____
Minor Course of Study: _____

MILITARY SERVICE:

Please check the appropriate box that indicates past or present active or reserve duty.

- ❑ United States Army
- ❑ United States Navy
- ❑ United States Air Force
- ❑ United States Marine Corps
- ❑ United States Coast Guard

Length of Service: _____

Military Specialty / Occupation: _____ Rank: _____

FIRE SERVICE BACKGROUND:

Please list any association, membership and / or employment with a Fire Department or Fire Service Agency or Organization.

Fire Dept. / Agency: _____ How Long? _____
City/Town: _____ State: _____

Fire Dept. / Agency: _____ How Long? _____
City/Town: _____ State: _____

Fire Dept. / Agency: _____ How Long? _____
City/Town: _____ State: _____

Please check the appropriate box indicating FIRE SERVICE <u>certification</u> levels that you have obtained and indicate any others not listed.

- ❑ Firefighter I
- ❑ Firefighter II
- ❑ Fire Officer I
- ❑ Fire Officer II
- ❑ Safety Officer
- ❑ Fire Marshal
- ❑ Other _____
- ❑ Fire Service Instructor I
- ❑ Fire Service Instructor II
- ❑ Pump Operator
- ❑ Aerial Operator
- ❑ Hazmat Technician
- ❑ Fire Inspector

Other _____

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: _____

Medication: _____ Reason: _____

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.

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

Allergies

To Be Completed by Recruit

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

_____

Symptoms:			**Give Checked Medication** To be determined by Physician Authorizing treatment	
If a food allergen has been ingested, but *no symptoms*:			☐ Epinephrine	☐ Antihistamine
Mouth	-	Itching, tingling, or swelling of lips, tongue, and/or mouth:	☐ Epinephrine	☐ Antihistamine
Skin	-	Hives, itchy rash, swelling of the face or extremities:	☐ Epinephrine	☐ Antihistamine
Gut	-	Itching, tingling, or swelling of lips, tongue, and/or mouth:	☐ Epinephrine	☐ Antihistamine
Throat ⌖	-	Tightening of throat, hoarseness, hacking cough:	☐ Epinephrine	☐ Antihistamine
Lung ⌖	-	Shortness of breath, repetitive coughing, wheezing:	☐ Epinephrine	☐ Antihistamine
Heart ⌖	-	Weak or thread pulse, low blood pressure, fainting, pale, blueness:	☐ Epinephrine	☐ Antihistamine
Other ⌖	-	_____:	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above areas affected), give:			☐ Epinephrine	☐ Antihistamine

⌖ - Potentially Life Threating. The severity of symptoms can quickly change

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: _____

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

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: _____

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

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.

Signature: _____ _____
(Recruit Applicant) Date

Authorization for Release of Contact Information

To Be Completed by Recruits or Graduate

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: ____ /____

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

Emergency Medical Training

To Be Completed by Recruit

The recruit applicant is required to have current Emergency Medical Service 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 _____

Name as Appears on Card: _____ Exp. Date: ___/___/___

CPR/AED Training

Card issued from:

□ American Red Cross

□ American Heart Association

□ Other: _____

Name as Appears on Card: _____ Exp. Date: ___/___/___

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

□ I have **NO CPR/AED Training**; the recruit does not have proof of a current CPR/AED related training course.

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

□ The Recruit will attend the CFA Recruit scheduled Basic First Aid and/or CPR/AED training.

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

Mission Statements

Connecticut Fire Academy Mission Statement

To prevent or mitigate the effects of fires and disasters, either natural or manmade, on the citizens of the State of Connecticut. This objective shall be accomplished through the development and delivery of state-of-the-art educational programs designed to meet nationally recognized standards, certification of individuals to such standards and maintenance of up-to-date resources for us by fire service personnel, public educators and other first responders.

Training Division Mission Statement

As part of the Commission on Fire Prevention and Control, the Training Division is responsible for the operation of the Connecticut Fire Academy to provide training, education, technical support and related information and services. Customers benefit from instructors using contemporary methods in a safe environment

Recruit's Fire Department Mission Statement

(to be filled in by the Recruit Firefighter)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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:

Prepared Recruit Application – Section 2 documents for collection:

- ☐ PAGE 1 – Recruit Personal Information Form
- ☐ PAGE 2 – Recruit Medical Information Form
- ☐ PAGE 3 – Allergies
- ☐ PAGE 4 – Emergency Contact Information
- ☐ PAGE 5 – Authorization for Release of Performance Information Form
- ☐ PAGE 5 – Authorization for Release of Contact Information Form *(Self-Pays Only)*
- ☐ PAGE 6– Emergency Medical Training
- ☐ PAGE 7 – Fire Academy and Fire Department Mission Statements
- ☐ PAGE 9 thru 12 – Physical Activity Readiness Questionnaire PAR-Q
- ☐ PAGE 13 – Medical Demographic Cards
- ☐ Completed - Self-Administered Physical Fitness Test
  *Recruits **MUST** perform the Physical Fitness Test prior to the first day*

Copies of Documents

- ☐ Copy of CPAT (Candidate Physical Ability Test) Certification
- ☐ Copy of EMS training Certification/License (EMR/EMT/EMT/P)
- ☐ Copy of CPR/AED Certification
- ☐ Copy of Fit Testing Information (if available)

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

Physical Activity Readiness Questionnaire (PAR-Q)

To Be Completed by Recruit

2017 PAR-Q+

The Physical Activity Readiness Questionnaire for Everyone

The health benefits of regular physical activity are clear; more people should engage in physical activity every day of the week. Participating in physical activity is very safe for MOST people. This questionnaire will tell you whether it is necessary for you to seek further advice from your doctor OR a qualified exercise professional before becoming more physically active.

GENERAL HEALTH QUESTIONS

Please read the 7 questions below carefully and answer each one honestly: check YES or NO.	YES	NO
1) Has your doctor ever said that you have a heart condition ☐ OR high blood pressure ☐?	☐	☐
2) Do you feel pain in your chest at rest, during your daily activities of living, **OR** when you do physical activity?	☐	☐
3) Do you lose balance because of dizziness **OR** have you lost consciousness in the last 12 months? Please answer **NO** if your dizziness was associated with over-breathing (including during vigorous exercise).	☐	☐
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
5) Are you currently taking prescribed medications for a chronic medical condition? **PLEASE LIST CONDITION(S) AND MEDICATIONS HERE:** _____	☐	☐
6) Do you currently have (or have had within the past 12 months) a bone, joint, or soft tissue (muscle, ligament, or tendon) problem that could be made worse by becoming more physically active? Please answer **NO** if you had a problem in the past, but it *does not limit your current ability* to be physically active. **PLEASE LIST CONDITION(S) HERE:** _____	☐	☐
7) Has your doctor ever said that you should only do medically supervised physical activity?	☐	☐

If you answered NO to all of the questions above, you are cleared for physical activity.
Go to Page 4 to sign the PARTICIPANT DECLARATION. You do not need to complete Pages 2 and 3.

- Start becoming much more physically active – start slowly and build up gradually.
- Follow International Physical Activity Guidelines for your age (www.who.int/dietphysicalactivity/en/).
- You may take part in a health and fitness appraisal.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.
- If you have any further questions, contact a qualified exercise professional.

If you answered YES to one or more of the questions above, COMPLETE PAGES 2 AND 3.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ at **www.eparmedx.com** before becoming more physically active.
- Your health changes - answer the questions on Pages 2 and 3 of this document and/or talk to your doctor or a qualified exercise professional before continuing with any physical activity program.

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01-01-2017

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

Physical Activity Readiness Questionnaire (PAR-Q)

To Be Completed by Recruit

2017 PAR-Q+

FOLLOW-UP QUESTIONS ABOUT YOUR MEDICAL CONDITION(S)

1. Do you have Arthritis, Osteoporosis, or Back Problems?
If the above condition(s) is/are present, answer questions 1a-1c — If **NO** ☐ go to question 2

1a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
1b.	Do you have joint problems causing pain, a recent fracture or fracture caused by osteoporosis or cancer, displaced vertebra (e.g., spondylolisthesis), and/or spondylolysis/pars defect (a crack in the bony ring on the back of the spinal column)?	YES ☐ NO ☐
1c.	Have you had steroid injections or taken steroid tablets regularly for more than 3 months?	YES ☐ NO ☐

2. Do you currently have Cancer of any kind?
If the above condition(s) is/are present, answer questions 2a-2b — If **NO** ☐ go to question 3

2a.	Does your cancer diagnosis include any of the following types: lung/bronchogenic, multiple myeloma (cancer of plasma cells), head, and/or neck?	YES ☐ NO ☐
2b.	Are you currently receiving cancer therapy (such as chemotheraphy or radiotherapy)?	YES ☐ NO ☐

3. Do you have a Heart or Cardiovascular Condition? *This includes Coronary Artery Disease, Heart Failure, Diagnosed Abnormality of Heart Rhythm*
If the above condition(s) is/are present, answer questions 3a-3d — If **NO** ☐ go to question 4

3a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
3b.	Do you have an irregular heart beat that requires medical management? (e.g., atrial fibrillation, premature ventricular contraction)	YES ☐ NO ☐
3c.	Do you have chronic heart failure?	YES ☐ NO ☐
3d.	Do you have diagnosed coronary artery (cardiovascular) disease and have not participated in regular physical activity in the last 2 months?	YES ☐ NO ☐

4. Do you have High Blood Pressure?
If the above condition(s) is/are present, answer questions 4a-4b — If **NO** ☐ go to question 5

4a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
4b.	Do you have a resting blood pressure equal to or greater than 160/90 mmHg with or without medication? (Answer **YES** if you do not know your resting blood pressure)	YES ☐ NO ☐

5. Do you have any Metabolic Conditions? *This includes Type 1 Diabetes, Type 2 Diabetes, Pre-Diabetes*
If the above condition(s) is/are present, answer questions 5a-5e — If **NO** ☐ go to question 6

5a.	Do you often have difficulty controlling your blood sugar levels with foods, medications, or other physician-prescribed therapies?	YES ☐ NO ☐
5b.	Do you often suffer from signs and symptoms of low blood sugar (hypoglycemia) following exercise and/or during activities of daily living? Signs of hypoglycemia may include shakiness, nervousness, unusual irritability, abnormal sweating, dizziness or light-headedness, mental confusion, difficulty speaking, weakness, or sleepiness.	YES ☐ NO ☐
5c.	Do you have any signs or symptoms of diabetes complications such as heart or vascular disease and/or complications affecting your eyes, kidneys, **OR** the sensation in your toes and feet?	YES ☐ NO ☐
5d.	Do you have other metabolic conditions (such as current pregnancy-related diabetes, chronic kidney disease, or liver problems)?	YES ☐ NO ☐
5e.	Are you planning to engage in what for you is unusually high (or vigorous) intensity exercise in the near future?	YES ☐ NO ☐

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01-01-2017

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

Physical Activity Readiness Questionnaire (PAR-Q)

To Be Completed by Recruit

2017 PAR-Q+

6. Do you have any Mental Health Problems or Learning Difficulties? *This includes Alzheimer's, Dementia, Depression, Anxiety Disorder, Eating Disorder, Psychotic Disorder, Intellectual Disability, Down Syndrome*

If the above condition(s) is/are present, answer questions 6a-6b If **NO** ☐ go to question 7

6a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
6b.	Do you have Down Syndrome **AND** back problems affecting nerves or muscles?	YES ☐ NO ☐

7. Do you have a Respiratory Disease? *This includes Chronic Obstructive Pulmonary Disease, Asthma, Pulmonary High Blood Pressure*

If the above condition(s) is/are present, answer questions 7a-7d If **NO** ☐ go to question 8

7a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
7b.	Has your doctor ever said your blood oxygen level is low at rest or during exercise and/or that you require supplemental oxygen therapy?	YES ☐ NO ☐
7c.	If asthmatic, do you currently have symptoms of chest tightness, wheezing, laboured breathing, consistent cough (more than 2 days/week), or have you used your rescue medication more than twice in the last week?	YES ☐ NO ☐
7d.	Has your doctor ever said you have high blood pressure in the blood vessels of your lungs?	YES ☐ NO ☐

8. Do you have a Spinal Cord Injury? *This includes Tetraplegia and Paraplegia*

If the above condition(s) is/are present, answer questions 8a-8c If **NO** ☐ go to question 9

8a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
8b.	Do you commonly exhibit low resting blood pressure significant enough to cause dizziness, light-headedness, and/or fainting?	YES ☐ NO ☐
8c.	Has your physician indicated that you exhibit sudden bouts of high blood pressure (known as Autonomic Dysreflexia)?	YES ☐ NO ☐

9. Have you had a Stroke? *This includes Transient Ischemic Attack (TIA) or Cerebrovascular Event*

If the above condition(s) is/are present, answer questions 9a-9c If **NO** ☐ go to question 10

9a.	Do you have difficulty controlling your condition with medications or other physician-prescribed therapies? (Answer **NO** if you are not currently taking medications or other treatments)	YES ☐ NO ☐
9b.	Do you have any impairment in walking or mobility?	YES ☐ NO ☐
9c.	Have you experienced a stroke or impairment in nerves or muscles in the past 6 months?	YES ☐ NO ☐

10. Do you have any other medical condition not listed above or do you have two or more medical conditions?

If you have other medical conditions, answer questions 10a-10c If **NO** ☐ read the Page 4 recommendations

10a.	Have you experienced a blackout, fainted, or lost consciousness as a result of a head injury within the last 12 months **OR** have you had a diagnosed concussion within the last 12 months?	YES ☐ NO ☐
10b.	Do you have a medical condition that is not listed (such as epilepsy, neurological conditions, kidney problems)?	YES ☐ NO ☐
10c.	Do you currently live with two or more medical conditions?	YES ☐ NO ☐

PLEASE LIST YOUR MEDICAL CONDITION(S) AND ANY RELATED MEDICATIONS HERE: _____

GO to Page 4 for recommendations about your current medical condition(s) and sign the PARTICIPANT DECLARATION.

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01-01-2017

Last Name: _____ First Initial: _____ M.I.: _____ Recruit No._____
(Office Only)

Physical Activity Readiness Questionnaire (PAR-Q)

To Be Completed by Recruit

2017 PAR-Q+

If you answered NO to all of the follow-up questions about your medical condition, you are ready to become more physically active - sign the PARTICIPANT DECLARATION below:

- It is advised that you consult a qualified exercise professional to help you develop a safe and effective physical activity plan to meet your health needs.
- You are encouraged to start slowly and build up gradually - 20 to 60 minutes of low to moderate intensity exercise, 3-5 days per week including aerobic and muscle strengthening exercises.
- As you progress, you should aim to accumulate 150 minutes or more of moderate intensity physical activity per week.
- If you are over the age of 45 yr and **NOT** accustomed to regular vigorous to maximal effort exercise, consult a qualified exercise professional before engaging in this intensity of exercise.

If you answered **YES** to **one or more of the follow-up questions** about your medical condition:

You should seek further information before becoming more physically active or engaging in a fitness appraisal. You should complete the specially designed online screening and exercise recommendations program - the **ePARmed-X+ at www.eparmedx.com** and/or visit a qualified exercise professional to work through the ePARmed-X+ and for further information.

Delay becoming more active if:

- You have a temporary illness such as a cold or fever; it is best to wait until you feel better.
- You are pregnant - talk to your health care practitioner, your physician, a qualified exercise professional, and/or complete the ePARmed-X+ **at www.eparmedx.com** before becoming more physically active.
- Your health changes - talk to your doctor or qualified exercise professional before continuing with any physical activity program.

- You are encouraged to photocopy the PAR-Q+. You must use the entire questionnaire and NO changes are permitted.
- The authors, the PAR-Q+ Collaboration, partner organizations, and their agents assume no liability for persons who undertake physical activity and/or make use of the PAR-Q+ or ePARmed-X+. If in doubt after completing the questionnaire, consult your doctor prior to physical activity.

PARTICIPANT DECLARATION

- All persons who have completed the PAR-Q+ please read and sign the declaration below.
- If you are less than the legal age required for consent or require the assent of a care provider, your parent, guardian or care provider must also sign this form.

I, the undersigned, have read, understood to my full satisfaction and completed this questionnaire. I acknowledge that this physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if my condition changes. I also acknowledge that a Trustee (such as my employer, community/fitness centre, health care provider, or other designate) may retain a copy of this form for their records. In these instances, the Trustee will be required to adhere to local, national, and international guidelines regarding the storage of personal health information ensuring that the Trustee maintains the privacy of the information and does not misuse or wrongfully disclose such information.

NAME _____ DATE _____

SIGNATURE _____ WITNESS _____

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER _____

For more information, please contact
www.eparmedx.com
Email: eparmedx@gmail.com

Citation for PAR-Q+
Warburton DER, Jamnik VK, Bredin SSD, and Gledhill N on behalf of the PAR-Q+ Collaboration. The Physical Activity Readiness Questionnaire for Everyone (PAR-Q+) and Electronic Physical Activity Readiness Medical Examination (ePARmed-X+). Health & Fitness Journal of Canada 4(2):3-23, 2011.

The PAR-Q+ was created using the evidence-based AGREE process (1) by the PAR-Q+ Collaboration chaired by Dr. Darren E. R. Warburton with Dr. Norman Gledhill, Dr. Veronica Jamnik, and Dr. Donald C. McKenzie (2). Production of this document has been made possible through financial contributions from the Public Health Agency of Canada and the BC Ministry of Health Services. The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada or the BC Ministry of Health Services.

Key References
1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shephard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation: background and overall process. APNM 36(S1):S3-S13, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bredin SSD, McKenzie DC, Stone J, Charlesworth S, and Shephard RJ. Evidence-based risk assessment and recommendations for physical activity clearance: Consensus Document. APNM 36(S1):S266-s298, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Davenport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal. 1975;17:375-378.
4. Thomas S, Reading J, and Shephard RJ. Revision of the Physical Activity Readiness Questionnaire (PAR-Q). Canadian Journal of Sport Science 1992;17:4 338-345.

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01-01-2017

The Department of Emergency Services and Public Protection
The Connecticut Fire Academy

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: □ Wife □ Parent □ Other; _____

Emergency Phone Numbers: □Home □Work: (___) _____ Cell: (___) _____

Cut Here (for Physical Training Copies, Reduce Original 65%) Cut Here

The Department of Emergency Services and Public Protection
The Connecticut Fire Academy

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: □ Wife □ Parent □ Other; _____

Emergency Phone Numbers: □Home □Work: (___) _____ Cell: (___) _____