



Mission: To inspire lifelong learning and leadership through experience, excellence and innovation.
Vision: Transforming the future through innovative learning.
Values: We value learner success, integrity, respect, community, excellence and innovation.



EMERGENCY TRAINING MEDICAL RELEASE FORM

The personal information requested on this form is collected under the authority of Section 33(c) of the Alberta Freedom of Information and Protection of Privacy Act and will be protected under the Act. Information is collected for the purpose of program admission. Information collected on this form is used in the normal course of College operations in accordance with this legislation. If you have any questions about the collection and use of this information, please contact the FOIP Coordinator (5707 College Drive, Vermilion AB; 780-853-8524; FOIP@lakelandcollege.ca).

To the applicant: Please complete pages 1 to 4 of this questionnaire and take the entire form with you to the medical examination by your physician.

This document can be faxed to 780 853-8594 or mailed to 5707 College Drive, Vermilion, Alberta T9X 1K5

****Please note that this document is only valid if completed within one year of your program start date.****

Date(D/M/Y): ____/____/____

Provincial Health Care #:

Name:

Family Name

Given Names

Date of Birth(D/M/Y): ____/____/____

Age: ____

Gender: M ____ F ____

Address: _____

Phone: _____

City: _____

Postal Code: _____

Present Health:

1. Good with no medical complaints _____
2. Symptoms or medical complaints _____
3. Are you presently on any treatment for any medical condition? YES ____ NO ____
If yes, please explain _____

Activity Related Problems:

Have you experienced any of the following conditions related to work or exercise?

- | | | |
|------------------|-----------------------------|-------------------------|
| 1. back problems | 2. chest pain | 3. dizziness |
| 4. fainting | 5. muscle or joint problems | 6. irregular heart beat |
| 7. wheezing | 8. other | |

Please explain: _____

Illnesses, operation, hospitalizations or injuries:

Date	Problem	Treatment	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications:

Please list any medications you are taking on a regular basis

_____	_____	_____
_____	_____	_____

Allergies:

Drug Allergies: _____

Other Allergies: _____

Past medical history:

Do you have, or have you ever had any of the following conditions? Check all that apply.

- Heart disease
- High blood pressure
- Lung disease including asthma
- Kidney disease
- Diabetes
- Bowel disease
- Cancer
- Mental health illness
- Epilepsy
- Head injury, loss of consciousness
- Fractures, or bone, joint, muscle, tendon, ligament problems
- Surgery
- Back problems
- Missing organs (e.g., eye, kidney)
- Tendonitis, carpal tunnel, whitehand
- Learning difficulties
- Other medical conditions not listed here

If you have checked off any of the above, please explain:

Occupational Exposure:

Have you or do you require use of protective equipment at any time to carry out your job duties (SCBA, respirator, noise protection)? Detail:

Have you ever worked in an area with exposure to noxious or toxic chemicals, gases, ionizing radiation (x-ray, gamma ray, etc.), radiant energy (UV, infra-red)? Describe:

Have you ever been required to change jobs or locations due to work conditions or exposures? Describe:

Have you ever had a hazardous substance exposure requiring treatment or time off work? If you have, please describe.

Family History:

Have any close family members (parents, siblings) had any illnesses? YES _____ NO _____
(e.g., heart disease, high blood pressure, stroke, diabetes, cancer, alcoholism, other)

Relation	Living	Age	Present Health	Deceased	Age	Cause
Father	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____
Brothers & Sisters	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____	_____

Lifestyle:

Smoking: Do you smoke? YES _____ NO _____
If YES how many per day? _____
If NO did you smoke in the past? YES _____ NO _____
If YES when did you quit? _____ months / years ago.

Alcohol: Do you drink alcohol? YES _____ NO _____
If YES, on average how many per week?
Beer (bottles) _____ Spirits (oz.) _____ Wine (oz.) _____

Exercise: Do you exercise on a regular basis? YES _____ NO _____
If YES please complete the table below:

Activity	Intensity (Hard/Easy)	Exercise Time	Times per week

Has a physician ever suggested that you be restricted from physical activity? **YES** _____ **NO** _____
If YES please explain. _____

Consent for independent medical examination and release of information:

The above information is correct and complete to the best of my knowledge.
I _____, hereby consent to a medical examination by
Dr. _____, who then has my consent to send a report of the findings to
Emergency Training Centre, Lakeland College (Vermilion, AB). I further authorize any physician who has attended or
examined me to release full details of my medical status to the above named physician upon their request.

Signature of Applicant: _____ Date: _____

Witness: _____ Date: _____

Medical Examination For Physician Use Only

The purpose of this document is to ensure that the applicant is medically fit to undertake live-fire training. A brief summary of the physical demands for the training courses is provided below. Further information may be obtained by contacting the Office of the Registrar at Lakeland College at (780) 853-8672.

Summary of Physical Demands:

This program includes both theoretical and practical study of structural/industrial firefighting, as well as a structured, credited physical training class, instructed by a qualified Certified Exercise Physiologist. The practical component normally includes multiple days of simulated fire suppression exercises where students are exposed to the physical demands normally associated with firefighting work. During a typical practical day, students may experience 4-6 training scenarios. Each scenario involves between 15-60 minutes of exposure to severe environmental and physical stress.

The physical training class (for the Emergency Services Technology program only) runs 3 times a week for an hour each session. The workouts are designed to stress all of the body's energy systems of aerobic, anaerobic, and muscular strength/endurance to peak limits. Workouts range from high intensity circuits, 5-10 km runs, 20 km bikes, hill/bleacher training, swimming, and industry specific training (Fire-Fit-Combat Challenge Simulation). Some of the major stressors are outlined below in more detail:

1. Tolerating extreme fluctuations in temperature while performing duties. Students are required to perform physically demanding work in hot (up to 150°C or 400°F), humid (up to 100%) atmospheres while wearing personal protective equipment that significantly impairs thermoregulation.¹ (Core body temperatures can reach up to 40°C after 20 min of hard work).
2. Wearing firefighting clothing and equipment that weighs at least 22 kg (50 lb) while performing firefighting work.¹
3. Performing physically demanding work while wearing positive pressure self-contained breathing apparatus (SCBA) which presents a significant resistance to expiratory flow and may reduce peak exercise ventilation by approximately 15%.^{1,2}
4. Making rapid transitions from rest to near maximal exertion without warm-up periods.¹
5. Operating in environments of high noise, poor visibility, limited mobility; at heights; and, in enclosed or confined spaces.¹
6. Using hose, ladders, and manual or power tools that weigh up to 45 kg (100 lb).^{3,4}
7. High levels of energy expenditure that are estimated to average approximately 8-10 METS^{4,5} and may exceed 12 METS.¹ Completion of Stage 3 of the Bruce treadmill protocol (3.4 mph and 14% grade) or running at 6.0 mph on level ground is equivalent to about 10 METS.
8. High levels of cardiovascular stress as evidenced by average heart rates of 70% of the age-predicted maximum during training scenarios with brief, repeated periods of near maximal heart rate (90+%).⁶

¹National Fire Protection Agency. (2003) Standard 1582, Medical Requirements for Fire Fighters and Information for Fire Department Physicians. Quincy, MA: National Fire Protection Association.

²Eves ND, Jones RL, Petersen SR (2005) The influence of the self-contained breathing apparatus (SCBA) on ventilatory function and maximal exercise. Canadian Journal of Applied Physiology 30(5): 507-519.

³DOT Occupational Codes. (1993) Selected Characteristics of Occupations Defined in the Revised Dictionary of Occupational Titles, U.S. Dept. of Labor, U.S. Government Printing Office, Washington, D.C.

⁴Gledhill, N., and Jamnik, V. K. (1992). Characterization of the physical demands of firefighting. Canadian Journal of Sport Science. 17: 207-213.

⁵Sothmann, M., Saupe, K., Jansenof, D., Blaney, J., Fuhrman, S. D., Woulfe, T., Raven, P., Pawelczyk, J., Dotson, C., Landy, F., Smith, J. J., and Davis, P. (1990). Advancing age and the cardiorespiratory stress of fire suppression: determining a minimum standard for aerobic fitness. Human Performance. 3: 217-236.

⁶Dreger, RW, Petersen, SR, Dlin RA. Heart rate responses to firefighter training. Final report submitted to the Alberta Fire Training School, March 2002.

Medical Examination For Physician Use Only

Name _____ Date of Birth (D/M/Y): ____/____/____

Height ____ in. ____ cm. Weight ____ lb. ____ kg.

Vision: Uncorrected _____ Corrected _____

Right: 20/ 20/

Left: 20/ 20/

Both: 20/ 20/

Colour: Normal _____ Impaired _____

Hearing:

R Normal _____ Impaired _____

L Normal _____ Impaired _____

Blood Pressure: _____ / _____ mmHg Pulse: _____ bpm

	<u>Normal</u>	<u>Abnormal</u>	<u>Not Examined</u>	<u>Findings</u>	<u>Follow-up Suggested</u>
General Assessment					
E.N.T.					
Pulmonary					
Cardiovascular					
Abdomen					
Musculoskeletal					
Genitourinary					
Neurological					

Comments on physical examination:

Medical Examination For Physician Use Only

Medical Clearance

I have examined _____ and am satisfied that this individual is medically fit to participate in the fire training course described above.

Physician's name: _____

Address: _____

Telephone: _____

Physician's signature: _____

Date: _____

The costs associated with completion of this form are the responsibility of the applicant.