







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

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

### Medications

*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: \_\_\_\_\_

### Allergies

*To Be Completed by Recruit*

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

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

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

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

**Allergies – Environment/Other** (insects/bees, soaps, lotions, pool chlorine, etc.):

*Please list any known allergies to environment or other*

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

### Symptoms of any Allergen:

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



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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: \_\_\_\_\_



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 Recruit 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 Firefighter Program’s scheduled Basic First Aid and/or CPR/AED training.





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

The recruit is also required to wear their Fire Department's standard daily work wear (FD Class B Work Shirt, Navy Trousers, Black or Navy Socks and Black Shoes or Work Boots) for the First day of class, Graduation and Special Events.

**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** (These documents will be collected on the first day):

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 and complete the document prior to the first day*

**Copies of Documents** (These copies will be collected on the first day):

- 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.: \_\_\_\_\_

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 (Office Only)

**Physical Activity Readiness Questionnaire (PAR-Q)**  
*To Be Completed by Recruit*

# 2020 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 <input type="checkbox"/> OR high blood pressure <input type="checkbox"/> ?	<input type="checkbox"/>	<input type="checkbox"/>
2) Do you feel pain in your chest at rest, during your daily activities of living, OR when you do physical activity?	<input type="checkbox"/>	<input type="checkbox"/>
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).	<input type="checkbox"/>	<input type="checkbox"/>
4) Have you ever been diagnosed with another chronic medical condition (other than heart disease or high blood pressure)? PLEASE LIST CONDITION(S) HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
5) Are you currently taking prescribed medications for a chronic medical condition? PLEASE LIST CONDITION(S) AND MEDICATIONS HERE: _____	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>
7) Has your doctor ever said that you should only do medically supervised physical activity?	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered NO to all of the questions above, you are cleared for physical activity. Please 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 Global Physical Activity Guidelines for your age (<https://apps.who.int/iris/handle/10665/44399>).
- 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.

**PARTICIPANT DECLARATION**  
 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 the community/fitness center may retain a copy of this form for its records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
 SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_  
 SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER \_\_\_\_\_

**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](http://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.



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

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

**Physical Activity Readiness Questionnaire (PAR-Q)**  
*To Be Completed by Recruit*

# 2020 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 chemotherapy 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 currently 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



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

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

**Physical Activity Readiness Questionnaire (PAR-Q)**  
*To Be Completed by Recruit*

# 2020 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? **YES**  **NO**   
 (Answer **NO** if you are not currently taking medications or other treatments)
- 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? **YES**  **NO**   
 (Answer **NO** if you are not currently taking medications or other treatments)
- 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? **YES**  **NO**   
 (Answer **NO** if you are not currently taking medications or other treatments)
- 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? **YES**  **NO**   
 (Answer **NO** if you are not currently taking medications or other treatments)
- 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.**



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

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

**Physical Activity Readiness Questionnaire (PAR-Q)**  
*To Be Completed by Recruit*

# 2020 PAR-Q+

**✓ If you answered NO to all of the FOLLOW-UP questions (pgs. 2-3) 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](http://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](http://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 the community/fitness center may retain a copy of this form for records. In these instances, it will maintain the confidentiality of the same, complying with applicable law.

NAME \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ WITNESS \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN/CARE PROVIDER \_\_\_\_\_

For more information, please contact  
[www.eparmedx.com](http://www.eparmedx.com)  
Email: [eparmedx@gmail.com](mailto:eparmedx@gmail.com)

**Creation for PAR-Q+**  
Warburton DER, Jamnik VK, Bradin 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):3-31, 2011.

**Key References**

1. Jamnik VK, Warburton DER, Makarski J, McKenzie DC, Shepard RJ, Stone J, and Gledhill N. Enhancing the effectiveness of clearance for physical activity participation: background and overall process. APNM 36(5):53-513, 2011.
2. Warburton DER, Gledhill N, Jamnik VK, Bradin SSD, McKenzie DC, Stone J, Charlesworth S, and Shepard RJ. Evidence-based risk assessment and recommendations for physical activity clearance; Consensus Document. APNM 36(5):5266-5285, 2011.
3. Chisholm DM, Collis ML, Kulak LL, Dewanport W, and Gruber N. Physical activity readiness. British Columbia Medical Journal 1975;17:375-378.

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.



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



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: (\_\_\_\_) \_\_\_\_\_