



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.



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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: 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: (____) _____



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(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, 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 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: ___/___/___

- I have 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: _____

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:
- 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
 - Completed of Self-Administered Physical Fitness Test
 - Copy of CPAT (Candidate Physical Ability Test) Certification
 - Copy of EMS training Certification/License (EMR/EMT/EMT/P)



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

Copy of CPR/AED Certification