St. Johns County Fire Rescue

3657 Gaines Road, Saint Augustine, Fl., 32084
Office: 904-209-1700 Fax: 904-209-1737

Pre - Employment Physical Exam

Open Water Lifeguard

Applicants Name	
Date of Birth	
Date	

Instructions:
Part 1 and Part 2

- Applicant must fill out form in its entirety and present to physician for evaluation
- Applicant must sign and date form

Part 3 (Physician)

- Physician complete examination and form
- Physician initial indicating exposure to ultraviolet ray has been discussed
- Clearance for duty has been indicated
- Physician signature and information with physician stamp
- Competed examination will be turned into Fire Rescue Administration to indicate applicants eligibility

Pre-Employment Physical Evaluation (BEACH LIFEGUARD)

Part 1. Applicant Information

Applicants Name

Date of Birth Sex Age

Home Address

Home Phone E-mail Address

Person to Contact in Case of Emergency

Relationship to Applicant

Home Phone Cell Phone Work Phone

Primary Physician City & State

Office Phone

Part 2. Medical History Explain "yes" answers below. Circle questions you don't know answers to.

	YES	NO
Have you had a medical illness or injury since your last check up or physical?	_____	_____
Do you have an ongoing chronic illness?	_____	_____
Have you ever been hospitalized overnight?	_____	_____
Have you ever had surgery?	_____	_____
Are you currently taking any prescription or non- prescription (over-the-counter) medications or pills or using an inhaler?	_____	_____
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	_____	_____
Do you have any allergies (for example, pollen, latex, medicine, food or stinging insects)?	_____	_____
Have you ever had a rash or hives develop during or after exercise?	_____	_____
Have you ever passed out during or after exercise?	_____	_____
Have you ever been dizzy during or after exercise?	_____	_____
Have you ever had chest pain during or after exercise?	_____	_____
Do you get tired more quickly than your friends do during exercise?	_____	_____
Have you ever had racing of your heart or skipped heartbeats?	_____	_____
Have you had high blood pressure or high cholesterol?	_____	_____
Have you ever been told you have a heart murmur?	_____	_____
Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	_____	_____
Has a physician ever denied or restricted your participation in sports for any heart problems?	_____	_____
Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters or pressure sores)?	_____	_____
Have you ever had a head injury or concussion?	_____	_____
Have you ever been knocked out, become unconscious or lost your memory?	_____	_____
Do you have asthma?	_____	_____

	YES	NO
Have you ever had a seizure?	_____	_____
Do you have frequent or severe headaches?	_____	_____
Have you ever had numbness or tingling in your arms, hands, legs or feet?	_____	_____
Have you ever had a stinger, burner or pinched nerve?	_____	_____
Have you ever become ill from exercising in the heat?	_____	_____
Do you cough, wheeze or have trouble breathing during or after activity?	_____	_____
Do you have seasonal allergies that require medical treatment?	_____	_____
Do you use any special protective or corrective equipment or medical devices that aren't usually used for your sport or position (for example, knee brace, special neck roll, foot orthotics, shunt, retainer on your teeth or hearing aid)?	_____	_____
Have you had any problems with your eyes or vision?	_____	_____
Do you wear glasses, contacts or protective eye wear?	_____	_____
Have you ever had a sprain, strain or swelling after injury?	_____	_____
Have you broken or fractured any bones or dislocated any joints?	_____	_____
Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	_____	_____
If yes, check appropriate blank and explain below:		
___ Head ___ Elbow ___ Hip		
___ Neck ___ Forearm ___ Thigh		
___ Back ___ Wrist ___ Knee		
___ Chest ___ Hand ___ Shin/Calf		
___ Shoulder ___ Finger ___ Ankle		
___ Upper Arm ___ Foot		
Do you want to weigh more or less than you do now?	_____	_____
Do you feel stressed out?	_____	_____
Have you ever been diagnosed with sickle cell anaemia?	_____	_____
Have you ever been diagnosed with having the sickle cell trait?	_____	_____

Record the dates of your most recent immunizations (shots) for

Tetanus: _____ Measles: _____

Hepatitis B: _____ Chickenpox: _____

Explain "Yes" Answers here:

I hereby state, to the best of my knowledge, that the answers to the above questions are complete and correct.

Signature of Applicant

Date

Part 3. Physical Examination (to be completed by licensed physician, , licensed chiropractic physician, licensed physician assistant or certified advanced registered nurse practitioner).

Applicants Name

Date of Birth | Weight | Height | Pulse

Blood Pressure | Temperature | % of Body Fat (Optional)

Hearing Right: P | Right: F | Left: P | Left: F

Visual Acuity Right 20/ | Left 20/ | Corrected ☐ Yes ☐ No | Pupils ☐ Equal ☐ Unequal

FINDINGS NORMAL ABNORMAL FINDINGS INITIALS*

Medical		Musculoskeletal	
Appearance		Neck	
Eyes/Ears/Nose/Throat		Back	
Lymph Nodes		Shoulder/Arm	
Heart		Elbow/forearm	
Pulses		Wrist/Hand	
Lungs		Hip/Thigh	
Abdomen		Knee	
Skin		Leg/ANkle	
		Foot	

ASSESSMENT OF EXAMINING PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER

I hereby certify that each examination listed above was performed by myself or an individual under my direct supervision with the following conclusion(s):

Prevention: As related to ultraviolet exposure, I have discussed with the examinee the need for eye and skin protection and the risk of skin cancer and appropriate protective measures.

Physician's Initials | Clearance: lifeguard is fit for duty: ☐ Yes ☐ No

Please specify each condition requiring clearance before examinee is considered fit for duty as a lifeguard

Physician Information

Name | Phone | Fax | Physician's Stamp

Address, City, State & Zip

Physician Signature | Date