HARVARD
Campus Services
ENVIRONMENTAL HEALTH & SAFETY

Respiratory Protection Medical Evaluation Form
For Medical Students
Using N95 Filtering Facepiece Respirators

Instructions

Harvard medical students are required by Harvard-affiliated hospitals to be prepared to work with potentially-infectious respiratory disease patients, and therefore are fitted with an N95 filtering facepiece respirator ("mask").

Respirator fit-testing cannot be performed until a medical evaluation is completed and reviewed.

The student who will be wearing the respirator must complete the following Respiratory Protection Medical Evaluation Form, which consists of two sections:

1. Fill in only your name and date of birth in **Section I - Health Care Provider's Recommendations**. Leave the rest of Section I blank for a health care provider, i.e., a physician or other licensed health care professional (PLHCP), to complete after reviewing the Section II Medical Questionnaire.
2. Complete **Section II - Medical Questionnaire**. This information is confidential, between you and the health care provider, and has absolutely no bearing on anything but the health care provider's recommendation.

In the case of medical students, place both sections of the completed form in an envelope provided for you in the HMS Office of Student Affairs. Put your name and Society on the envelope.

Student Affairs, as your representative, will be responsible for submitting all collected forms for review by the health care providers at:

Harvard University Health Services
Medical Area Health Service
275 Longwood Avenue
Boston, MA 02115
Phone: 617 432-1370
Fax: 617 432-7120

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For Students
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To be filled out by a physician or other licensed health care professional

I. Health Care Provider's Recommendation

The following recommendation regarding the use of respiratory protection is made using the medical questionnaire in Section II or an initial medical exam that obtains the same information as the questionnaire:

Name of Student: _____ Date of Birth: _____

☐ Follow-up medical evaluation required

☐ Medically cleared for respirator use

- ☐ No restrictions
- ☐ With following restrictions _____

_____

☐ NOT medically cleared for respirator use

Comments: _____

_____

_____

_____

By my signature, I also indicate that a copy of this recommendation has been provided to the student or his/her representative.

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name: _____

II. Medical Questionnaire

To the Student:

Are you able to read and understand the questions contained in this evaluation? ☐ Yes ☐ No

The University must allow you to answer this questionnaire at a time and place that is convenient to you. To maintain your confidentiality, your school administrators must not look at or review your answers.

Part A. Section 1.

Please print.

Name: _____ Today's Date: _____ /_____ /_____

Date of Birth: ____/_____/_____ Height: _____ ft. _____ in. Weight: _____ lbs. Sex: ☐ Male ☐ Female

Phone: (_____) _____ - _____ The best time to reach you at this number: _____

Has the University informed you about how to contact the health care professional (e.g., at University Health Services) who will review this questionnaire? ☐ Yes ☐ No

The type of respirator you will be fitted for: N95 Filtering Facepiece (e.g., provided at hospitals/clinics)

Have you ever worn a respirator? ☐ Yes ☐ No If yes, what type(s)?_____

Part A. Section 2.

All questions (1 through 9) must be answered.

	Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you ever had any of the following conditions?		
Seizures (fits)	☐	☐
Diabetes (sugar disease)	☐	☐
Allergic reactions that interfere with your breathing	☐	☐
Claustrophobia (fear of closed-in places)	☐	☐
Trouble smelling odors	☐	☐
3. Have you ever had any of the following pulmonary or lung problems?		
Asbestosis	☐	☐
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Tuberculosis	☐	☐
Silicosis	☐	☐
Pneumothorax (collapsed lung)	☐	☐
Lung cancer	☐	☐
Broken ribs	☐	☐
Any chest injuries or surgeries	☐	☐
Any other lung problem that you have been told about	☐	☐

	Yes	No
4. Do you currently have any of the following symptoms of pulmonary or lung illness?		
Shortness of breath	☐	☐
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
Have to stop for breath when walking at your own pace on level ground	☐	☐
Shortness of breath when washing or dressing yourself	☐	☐
Shortness of breath that interferes with your job	☐	☐
Coughing that produces phlegm (thick sputum)	☐	☐
Coughing that wakes you early in the morning	☐	☐
Coughing that occurs mostly when you are lying down	☐	☐
Coughing up blood in the last month	☐	☐
Wheezing	☐	☐
Wheezing that interferes with your job	☐	☐
Chest pain when you breathe deeply	☐	☐
Any other symptoms that you think may be related to lung problems	☐	☐
5. Have you ever had any of the following cardiovascular or heart problems?		
Heart attack	☐	☐
Stroke	☐	☐
Angina	☐	☐
Heart failure	☐	☐
Swelling in your legs or feet (not caused by walking)	☐	☐
Heart arrhythmia (heart beating irregularly)	☐	☐
High blood pressure	☐	☐
Any other heart problem that you have been told about	☐	☐
6. Have you ever had any of the following cardiovascular or heart symptoms?		
Frequent pain or tightness in your chest	☐	☐
Pain or tightness in your chest during physical activity	☐	☐
Pain or tightness in your chest that interferes with your job	☐	☐
In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
Heartburn or indigestion that is not related to eating	☐	☐
Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you currently take medication for any of the following problems?		
Breathing or lung problems	☐	☐
Heart trouble	☐	☐
Blood pressure	☐	☐
Seizures (fits)	☐	☐
8. If you have used a respirator, have you ever had any of the following problems?		
☐ Check here if you've never used a respirator and move on to question 9.		
Eye irritation	☐	☐
Skin allergies or rashes	☐	☐
Anxiety	☐	☐
General weakness or fatigue	☐	☐
Any other problem that interferes with your use of a respirator	☐	☐
9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?	☐	☐

If yes, please make sure to provide your legible 10-digit phone number in Part A Section 1 on the previous page.