



## **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:

- (i) In Section I – Health Care Provider’s Recommendations, fill in only your name and date of birth at the top of page 2.
- (ii) In Section II – Medical Questionnaire, complete pages 3 and 4 in their entirety.
- (iii) Send an e-mail with the entire 4-page document attached to [MAhealthservices@huhs.harvard.edu](mailto:MAhealthservices@huhs.harvard.edu)

# Respiratory Protection Medical Evaluation Form for Medical Students

## Using N95 Filtering Facepiece Respirators

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

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Comments

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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
<b>1. Do you currently smoke tobacco, or have you smoked tobacco in the last month</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Have you ever had any of the following conditions?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes (sugar disease)	<input type="checkbox"/>	<input type="checkbox"/>
Allergic reactions that interfere with your breathing	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia (fear of closed-in places)	<input type="checkbox"/>	<input type="checkbox"/>
Trouble smelling odors	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Have you ever had any of the following pulmonary or lung problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Asbestosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Silicosis	<input type="checkbox"/>	<input type="checkbox"/>
Pneumothorax (collapsed lung)	<input type="checkbox"/>	<input type="checkbox"/>
Lung cancer	<input type="checkbox"/>	<input type="checkbox"/>
Broken ribs	<input type="checkbox"/>	<input type="checkbox"/>
Any chest injuries or surgeries	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Do you currently have any of the following symptoms of pulmonary or lung illness?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when walking fast on level ground or walking up a slight hill or incline	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when walking with other people at an ordinary pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>

Have to stop for breath when walking at your own pace on level ground	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath when washing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that produces phlegm (thick sputum)	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that wakes you early in the morning	<input type="checkbox"/>	<input type="checkbox"/>
Coughing that occurs mostly when you are lying down	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood in the last month	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain when you breathe deeply	<input type="checkbox"/>	<input type="checkbox"/>
Any other symptoms that you think may be related to lung problems	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Have you ever had any of the following cardiovascular or heart problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>
Heart failure	<input type="checkbox"/>	<input type="checkbox"/>
Swelling in your legs or feet (not caused by walking)	<input type="checkbox"/>	<input type="checkbox"/>
Heart arrhythmia (heart beating irregularly)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Any other heart problem that you have been told about	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Have you ever had any of the following cardiovascular or heart symptoms?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent pain or tightness in your chest	<input type="checkbox"/>	<input type="checkbox"/>
Pain or tightness in your chest during physical activity	<input type="checkbox"/>	<input type="checkbox"/>
Pain or tightness in your chest that interferes with your job	<input type="checkbox"/>	<input type="checkbox"/>
In the past two years, have you noticed your heart skipping or missing a beat	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn or indigestion that is not related to eating	<input type="checkbox"/>	<input type="checkbox"/>
Any other symptoms that you think may be related to heart or circulation problems	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Do you currently take medication for any of the following problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing or lung problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Seizures (fits)	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. If you have used a respirator, have you ever had any of the following problems?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Check here if you've never used a respirator and move on to question 9.		
Eye irritation	<input type="checkbox"/>	<input type="checkbox"/>
Skin allergies or rashes	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
General weakness or fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Any other problem that interferes with your use of a respirator	<input type="checkbox"/>	<input type="checkbox"/>
<b>9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire?</b>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please make sure to provide your legible 10-digit phone number in Part A Section 1 on the previous page.		