

**BERGEN COMMUNITY COLLEGE
HEALTH SERVICES RECORD
OFFICE: 201-447-9257 FAX: 201-447-0327**

_____/_____/_____ M / F _____
Last Name (Please Print) First Middle initial (circle) Social Security # or ID #

_____/_____/_____/_____
Address: Street City State Zip Code

Telephone Home: _____ Work: _____ Date of Birth: _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Name _____
Telephone Home: _____ Work: _____

Part A: Student Complete. Please answer all questions as completely as possible.

	Y	N	Explain/List/Date
1. Head injury / fainting / seizure ?	___	___	_____
2. Eye injury/loss of vision ?	___	___	_____
3. Broken bone ?	___	___	_____
4. Hospitalization or surgery ?	___	___	_____
5. Diabetes, Heart, Lung, Asthma, Cancer, or other serious illness ?	___	___	_____
6. Anxiety / emotional / mental illness ?	___	___	_____
7. Other health problems ?	___	___	_____
8. Allergies: food/ medications / environmental	___	___	_____
9. Take any medications regularly ?	___	___	_____

Part B: Health Care Provider/Physician Complete: Please indicate immunizations with dates. If an immunization is not given for medical reasons, please attach signed statement with reason for exemption. **No exemptions for Nursing and Health Professions.**

IMMUNIZATIONS: *MMR#1, SECOND DOSE OF MEASLES VACCINE AND HEPATITIS B SERIES ARE MINIMUM REQUIREMENTS FOR FULL TIME NJ COLLEGE STUDENTS.

Vaccine	Mo/Day/Yr	Blood test/titer (if applicable)	<u>Exemptions – other than medical</u>
MMR#1(age 1yr or older)	_____		Health Professions. 1. Religious - submit signed statement of conflict with religious views 2. Age-born before 1957-MMR 3. No age exemption–HepB
*MMR#2 (30 days after#1)	_____	No Exemptions for Nursing &	
Measles	_____	Measles IgG: _____ Date: _____	
Mumps	_____	Mumps IgG: _____ Date: _____	
Rubella	_____	Rubella IgG: _____ Date: _____	
Hepatitis B Vaccine 1. _____ 2. _____ 3. _____		or HepB surface antibody titer or anti-HBs titer	
If test/titer is negative, you must be vaccinated. (copies of lab reports must be attached)			

CENTER FOR DISEASE CONTROL RECOMMENDS:

Tetanus within 10 years _____ Mantoux:Date _____ Results _____ mm
Meningitis 1 _____ 2 _____ Menactra _____ Varicella vaccine 1 _____ 2 _____

MANDATORY for All Nursing and Health Professions ONLY

MMR and Hepatitis B requirements as above. Tetanus date of last Booster: (must be within 10 years) _____
Varicella (Chicken pox) IgG blood test (titer): _____ (Copy of lab report must be attached)
OR Varivax Dose#1 _____ Dose#2 _____ (4 to 6 weeks apart) (Varivax **required** if titer is negative)
TB skin test date within 6 months: _____ Results:Neg () Pos _____ mm. If PPD is positive, Chest x-ray report within 1 yr. of start program
Name of Health/Medical Insurance Company/Group and Address _____
Policy or Group # _____ expiration date _____ (copy of card must be attached)

Signature: Health Care Professional/Physician Stamp/Address

Date

**BERGEN COMMUNITY COLLEGE
HEALTH SERVICES MEDICAL RECORD
OFFICE: 201-447-9257 FAX 201-447-0327**

Part C:/page 2 Health Care Provider/Physician complete:

Patient's Name: _____ Date of Birth _____ Date: _____

Address: Street _____ City _____ State _____ Zip Code _____

Emergency Contact: Name _____ Telephone _____

Height: _____ Weight: _____ Blood/Pressure: _____ Pulse: _____ Respirations: _____ Temp: _____

Allergies: _____ Medications: _____

General Appearance: _____

<u>Review of Systems:</u>	<u>Norm</u>	<u>Abnor</u>	<u>Comments/Description</u>
<u>Skin</u> (acne, fungus infection)	_____	_____	_____
<u>Head/Neck</u> (masses, range of motion, pain on motion)	_____	_____	_____
<u>Glands</u> (cervical, axillary, inguinal)	_____	_____	_____
<u>Eyes</u> (conjunctiva, jaundice)	_____	_____	_____
<u>Ears</u> (infection, perforation, hearing)	_____	_____	_____
<u>Nose</u> (obstruction)	_____	_____	_____
<u>Mouth/Teeth/Throat</u>	_____	_____	_____
<u>Chest</u>	_____	_____	_____
<u>Lungs</u> (chronic bronchitis, asthma)	_____	_____	_____
<u>Heart</u> (murmurs, click, rhythm)	_____	_____	_____
<u>Abdomen</u> (Liver, spleen, masses)	_____	_____	_____
<u>Back</u> (deformity, range of motion, scoliosis)	_____	_____	_____
<u>Extremities</u> (range of motion, deformity, weakness, scars)	_____	_____	_____
<u>Neurological</u> (reflexes, balance, coordination)	_____	_____	_____

Clinical Impression based on history and physical exam:

Recommendations: For this student:
 ___ May participate in physical activities
 ___ Needs health problems evaluated prior to participation in physical activities
 ___ Health problem limits participation in physical activities: _____
 ___ Limit classroom and physical activities as follows: _____

Comments or Recommendations:

Signature: Health Care Professional/Physician: _____ **Date:** _____

Health Care Address Stamp

Rev 03/08