

**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