

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

ID# _____

E-mail: _____

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

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

Telephone Home: _____ Work: _____ Cell: _____ 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.

**Immunizations: MMR#1 and MMR#2 requirements for full-time and part-time students.
Hepatitis B vaccine series are requirements for all full-time BCC students.**

Vaccine	Mo/Day/Yr	Blood test/titer (if applicable)	<u>Exemptions – other than medical</u>
MMR#1 (age 1yr or older)	_____		No Exemptions for Nursing & Health Professions.
MMR#2 (30 days after#1)	_____		
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	1. Religious – submit signed statement of conflict with religious beliefs.
If test/titer is negative, you must be vaccinated. (COPIES OF LAB REPORTS MUST BE ATTACHED.)			2. Age-born before 1957- MMR
Tdap _____ date (recommended)			3. No age exemption – HepB

Signature: Health Care Professional/Physician: _____ Date: _____
Health Care Address & STAMP: _____

THIS MEDICAL EXAM MUST BE RETURNED TO HEALTH SERVICES BEFORE STARTING CLASSES.
IF YOU ARE A NURSING AND HEALTH PROFESSIONS STUDENT, THIS MEDICAL EXAM MUST BE DATED, SIGNED AND
STAMPED WITHIN 6 MONTHS OF STARTING YOUR PROGRAM IN ORDER TO BE CLEARED FOR CLINICAL.

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: _____

Review of Systems:

	<u>Norm</u>	<u>Abnor</u>	<u>Comments/ Description</u>
<u>Skin</u>	_____	_____	_____
<u>Head, Ears, Nose, Throat</u>	_____	_____	_____
<u>Glands</u> (cervical, axillary, inguinal)	_____	_____	_____
<u>Eyes</u>	_____	_____	_____
<u>Chest</u>	_____	_____	_____
<u>Lungs</u> (chronic bronchitis, asthma)	_____	_____	_____
<u>Heart</u> (murmurs, click, rhythm)	_____	_____	_____
<u>Abdomen</u> (Liver, spleen, masses)	_____	_____	_____
<u>Musculoskeletal</u>	_____	_____	_____
<u>Metabolic/Endocrine</u>	_____	_____	_____
<u>Neurological/Neuropsychiatric</u>	_____	_____	_____

Allergies to food or medicines: (Please list) _____

Medical condition(s) requiring ongoing care: _____

Clinical Impression based on history and physical exam: _____

MEDICATIONS:

Diagnosis:	Medication:

Recommendations: For this student:

- _____ May participate in physical activities
- _____ Needs health problems evaluated prior to participation in physical activities
- _____ Limit classroom and physical activities as follows: _____
- _____ No participation due to: _____

Comments or Recommendations: _____

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

Health Care Address & STAMP: _____

Please be advised that this information will not be shared. However there may be a time when our Professional Staff may need to confer with other campus Professionals or appropriate health care providers in the event of an emergency.