Bergen Community College
400 Paramus Rd. Room HS100
Paramus, NJ 07652
Phone: 201-447-9257
healthservices@bergen.edu

NURSING AND HEALTH PROFESSIONS
IMMUNIZATION REQUIREMENT FORM

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

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

Contact: Home: _____ Work:_____ Cell:_____ Date of Birth:_____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:
Name _____
Contact Home:_____Work:_____Cell:_____

Part A: Student: 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	___	___	_____
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:
ALL Nursing and Health Profession students are **required to have titers drawn** for Measles (Rubeola), Mumps, Rubella, Varicella and Hepatitis B surface Antibody. **Laboratory reports must be attached.** If test/titer is negative or equivocal you must be revaccinated.

Measles (Rubeola) IgG:	_____ date drawn	_____ IgG Titer Value	☐ immune ☐ not immune	_____ Revaccination date if titer is negative or equivocal
Mumps IgG:	_____ date drawn	_____ IgG Titer Value	☐ immune ☐ not immune	_____ Revaccination date if titer is negative or equivocal
Rubella (German measles IgG)	_____ date drawn	_____ IgG Titer Value	☐ immune ☐ not immune	_____ Revaccination date if titer is negative or equivocal
Hepatitis B Surface Antibody titer	_____ date drawn	_____ IgG Titer Value	☐ immune ☐ not immune	#1_____ #2_____ #3_____ Revaccination dates if titer is negative or signed declination
Varicella IgG (chicken pox)	_____ date drawn	_____ IgG Titer Value	☐ immune ☐ not immune	#1_____ #2_____ Revaccination dates if titer is negative or equivocal

Tdap _____ (Must be within 10 Years) **Meningococcal** 2 doses age 11-18 yrs.old or 1 dose age 19-30 yrs.old **attach record**
Influenza vaccination when in season must have signature of admInistrator (If pharmacy administrator backup required)
Tuberculosis TB Screening: 2 STEP required for first year students, please see attached form.
Name of Health/Medical Insurance Company/Group _____ (**copy of card must be attached)**

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

BERGEN COMMUNITY COLLEGE **ID#_____**
HEALTH SERVICES MEDICAL RECORD
OFFICE: 201-447-9257 FAX 201-447-0327 **E-mail: _____**

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

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.