

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**

Program of study \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ 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 #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
 not immune Revaccination dates if titer is negative or  
signed declination

Varicella IgG \_\_\_\_\_  
(chicken pox) date drawn IgG Titer Value  immune #1 \_\_\_\_\_ #2 \_\_\_\_\_  
 not immune 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  
HEALTH SERVICES MEDICAL RECORD  
OFFICE: 201-447-9257 FAX 201-447-0327**

ID# \_\_\_\_\_

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:**

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

Allergies to food or medicines: (Please list) \_\_\_\_\_

Medical condition(s) requiring ongoing care: \_\_\_\_\_

Clinical Impression based on history and physical exam: \_\_\_\_\_

**MEDICATIONS:**

<b>Diagnosis:</b>	<b>Medication:</b>

**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.