ID#_______________

**BERGEN COMMUNITY COLLEGE**
**HEALTH SERVICES RECORD/ROOM HS100**
**healthservices@bergen.edu**
**OFFICE: 201-447-9257** **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, MMR#2 and Meningococcal vaccines are the minimum requirement for all part-time and full-time students, Hepatitis B vaccine series are minimum requirements for full-time BCC students.

| Vaccine | Mo/Day/Yr | Blood test/titer (if applicable) |
|---|---|---|
| MMR#1(age 1yr or older) | ____________ | |
| 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

**IF ANY TEST ARE NEGATIVE A VACCINATION OR VACCINATION SERIES IS REQUIRED (COPIES OF LAB REORTS, IMMUNE OR NON-IMMUNE MUST BE ATTACHED)**

Meningococcal at age 11yrs old-18yrs old 1. ___________2.____________

Meningococcal at age 19yrs old–23yrs old 1.________________

**Exemptions – other than medical**

**No Exemptions for Nursing & Health Professions.**

**1.** Religious – submit signed statement of conflict with religious belief.
**2.** Age-born before 1957-MMR
**3.** No age exemption – HepB

Signature: Health Care Professional/Physician: ______________________________ Date: ____________

Health Care Provider Name, Address and Stamp Printed:________________________________________

**FORM SUBMISSION LINK: https://lf.bergen.edu/forms/hs0002**

ID# ____________

**BERGEN COMMUNITY COLLEGE**
**HEATLTH SERVICES MEDICAL RECORD**
healthservices@bergen.edu
**OFFICE: 201-447-9257** **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:** _______________________________________________________

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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.