ID#_____

**BERGEN COMMUNITY COLLEGE**
**HEALTH SERVICES RECORD/ROOM HS100**
healthservices@bergen.edu
**Office:(201)447-9257 Fax: (201) 447-0327** **Email:**_____

_____/_____/_____ M / F _____
Last Name (Please Print) First Middle initial (circle) 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: _____ Cell _____ 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 a signed statement with reason for exemption.

## Immunizations: MMR#1, MMR#2 and MenACWY or MenA,B,C,W or Y 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** | **OR Blood test/titer (if applicable)** |
|---|---|---|
| MMR#1(age 1yr or older) | _____ | |
| MMR#2 (30 days after#1) | _____ | |
| Measles | _____ | OR Measles IgG: _____ Date: _____ |
| Mumps | _____ | OR Mumps IgG: _____ Date: _____ |
| Rubella | _____ | OR Rubella IgG: _____ Date: _____ |
| Hepatitis B Vaccine 1._____2._____3._____ | | OR HepB surface antibody blood/ titer or anti-HBs titer |
| Heplisav-B series 1._____2._____ | | |

**IF ANY BLOOD TESTS ARE NEGATIVE, A VACCINATION OR VACCINATION SERIES IS REQUIRED (COPIES OF LAB REPORTS MUST BE ATTACHED)**
MenACWY or Men ABCWY if under the age of 23 yrs.old 1._____2._____

**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-Hep B

**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**
**HEALTH SERVICES MEDICAL RECORD**

healthservices@bergen.edu
**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:** | No rm | Ab nor | 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:** _____

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

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.