

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

**NURSING & HEALTH PROFESSIONS
IMMUNIZATION & PHYSICAL FORM**

Program of study _____

form submission link: <https://lf.bergen.edu/forms/hs0001>

_____/_____/_____ M/F _____
Last Name (Please Print) First Middle initial (circle) BCC email address

_____/_____/_____/_____
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 either positive or negative.** If test/titer is negative or equivocal you must be revaccinated.

Measles (Rubeola) IgG:	_____	_____	<input type="checkbox"/> immune	_____
date drawn	IgG Titer Value		<input type="checkbox"/> not immune	Revaccination date if titer is negative or equivocal
Mumps IgG:	_____	_____	<input type="checkbox"/> immune	_____
date drawn	IgG Titer Value		<input type="checkbox"/> not immune	Revaccination date if titer is negative or equivocal
Rubella (German measles IgG)	_____	_____	<input type="checkbox"/> immune	_____
date drawn	IgG Titer Value		<input type="checkbox"/> not immune	Revaccination date if titer is negative or equivocal
Hepatitis B Surface Antibody titer	_____	_____	<input type="checkbox"/> immune	#1_____ #2_____ #3_____
date drawn	IgG Titer Value		<input type="checkbox"/> not immune	Revaccination dates if titer is negative or signed declination
Varicella IgG (chicken pox)	_____	_____	<input type="checkbox"/> immune	#1_____ #2_____
date drawn	IgG Titer Value		<input type="checkbox"/> not immune	Revaccination dates if titer is negative or equivocal or attach record

Tdap _____ (Must be within 10 Years)

MenACWY or Men ABCWY 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. **Covid-19 vaccine** attachment.

Name of Health/Medical Insurance Company/Group _____ (copy of card must be attached)

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

Health Care Address & STAMP: _____

STUDENT ID# _____

**BERGEN COMMUNITY COLLEGE
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: _____

<u>Review of Systems:</u>	<u>Nor</u>	<u>Ab</u>	<u>Comments/ Description</u>
<u>Skin</u>	<u>m</u>	<u>nor</u>	_____
<u>Head, Ears, Nose, Throat</u>	—	—	_____
<u>Glands (cervical, axillary, inguinal)</u>	—	—	_____
<u>Eyes</u>	—	—	_____
<u>Chest</u>	—	—	_____
<u>Lungs (chronic bronchitis, asthma)</u>	—	—	_____
<u>Heart (murmurs, click, rhythm)</u>	—	—	_____
<u>Abdomen (Liver, spleen, masses)</u>	—	—	_____
<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.