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._____

Covid-19 vaccine card attachment required for **all** students attending in person semester.

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

BERGEN COMMUNITY COLLEGE **ID#_____**
HEALTH 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.