The College of New Jersey

Career & Community Studies CCS

Health Form
(See attached)

All students are required to SUBMIT COMPLETED FORM to:
Career & Community Studies CCS
The College of New Jersey
2000 Pennington Rd
Ewing NJ 08628

DUE DATE for fall term: 7-31-10

In addition to the attached form, you will need to provide us with the following information: (All students **are required** to have a local doctor)

Physician Name _____Contact number_____

Insurance Carrier_____ Policy Group No. _____

Please list any allergies or dietary restrictions your student has: _____
_____
_____

Please list any medications your student is taking. Include time taken and dosage amount.

Medication	Dosage	Time taken

Is your student under medical care for any illness or condition, including a seizure disorder?

_____
_____
_____

Does your student require any special assistance for any physical limitations he/she may have?

Are there other aspects of your student's health that you would like to tell us about?

Signature_____ Date_____

PHYSICAL EXAMINATIOTION

Required for all Career & Community Studies Students

To be completed by a physician, nurse practitioner, or physician's assistant based on a physical evaluation performed within one year before TCNJ entry (as long as the student's health status has not changed since the physical was done).

EXAMINER: Your patient has been accepted at The College of New Jersey Career & Community Studies program. Please address the following during this visit:

- Required immunizations as indicated below or proof of immunity.
  - I. Measles, Mumps, Rebella,
  - II. Varicella (chicken pox)
  - III. Tetanus-Diphtheria-Pertussis
  - IV. Hepatitis B
- If high-risk for Tuberculosis, administer Tuberculin Skin Test or QuantiFERON-TB Gold test.
- Assess need for dental, vision or gynecological care & provide referral.
- Address medical, emotional, sleep, behavioral & addiction problems. Develop a plan with your patient for continued care & support before he/she comes to college.

Patient's Name:_____ Birth date:_____

Blood pressure_____ Pulse: _____ Height: _____ Weight: _____	URINALYSIS (optional) Protein: _____ Glucose: _____	VISION Left Right Uncorrrected: _____ _____ Corrected: _____ _____ _____Glasses _____Contact lenses

	Normal	Abnormal	Description of Any Abnormalities/Renmarks
Skin			
Neck/Thyroid			
Cardiovascular			
Lungs			
Breasts			
Abdominal			
Genito-urinary			
Neeurological			
Musculoskeletal			

Does this patient, to the best of your knowledge, have a current or past history of significant chronic or acute medical, psychological, emotional or addiction issues?____No____Yes If Yes, please describe (may attach summary to this form):_____
_____
_____

Comments/Recommendations:_____
_____

Examining Practitioner's Signature:_____ Date: _____

Examining Practitioner's (Print name):_____ Telephone:_____

Address or office stamp:_____