Dear Nursing Student,

It is my pleasure to welcome you on behalf of the faculty and staff of the Nursing Program to Bergen Community College. I wish you success in your professional and personal goals. To that end, myself, the faculty, and staff are committed to assist you as you begin this incredible journey culminating in your entry into the profession of nursing.

This nursing program prepares its graduates to become leaders of tomorrow by integrating classroom content with real life patient interactions in a variety of healthcare facilities. The program uses cutting edge technology such as the Human Patient Simulator to provide simulated experiences. This amazing learning tool enables you to practice your clinical skills before embarking into the clinical areas.

Graduates of the Bergen Community College Nursing Program are sought after by every healthcare facility in the college’s service area. Graduates of the program consistently report that they “were extremely well prepared to begin their nursing career”. Other indicators of success is that the program is fully accredited by the National League for Nursing Accreditation Commission and the New Jersey Board of Nursing.

Your future begins here and now. Best wishes for success.

Sincerely,

Dawn Kozlowski, PhD, RN, CNE
Associate Dean of Nursing
BRING THE COMPLETED REQUIREMENTS WITH YOU TO ORIENTATION ON:

JANUARY 7, 2014 – 6PM – Room TEC-128

ATTENDANCE IS MANDATORY

1. ____ Completed Health Services Records
   These forms must be filed with the Office of Health Services, Room HS100. Once they receive all of your health requirements, you will receive a BLUE CLEARANCE FORM. Bring this form with you.

2. ____ Obtain Malpractice Insurance
   Nursing students are required to purchase liability insurance. You can purchase the insurance from any company. You can also apply online at www.nso.com or you can call toll free 1-800-247-1500. Bring a copy of the Certificate of Insurance with you. Proof of payment will not be accepted.

3. ____ Obtain CPR CERTIFICATION
   Your card must be issued by the AMERICAN HEART ASSOCIATION OR THE AMERICAN RED CROSS ONLY.

   Cards issued by other institutions or associations will not be accepted.
BERGEN COMMUNITY COLLEGE
HEALTH SERVICES RECORD

Last Name (Please Print) ___________________________ / ___________________________/ ________/__________/ __________/________/ M / F _______ 

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: _____________________________ Cell: _____________________________ 

Part A: Student To Complete 
1. Head injury / fainting / seizure ______ ______ ______ Explain/List/Date _____________________________ 
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 Hepatitis B vaccine series are minimum requirements for full-time BCC students. 

Vaccine Mo/Day/Yr Blood test/titer (if applicable) Exemptions – other than medical
MMR#1 (age 1yr or older) *MMR#2 (30 days after#1) 
*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 test/titer is negative, you must be vaccinated. (copies of lab reports must be attached) 
Exemptions – other than medical
1. Religious - submit signed statement of conflict with religious views 
2. Age-born before 1957-MMR 
3. No age exemption–HepB 

CENTER FOR DISEASE CONTROL RECOMMENDS: 
Tetanus: Td / Tdap (circle one) within 10 years Date: __________ Mantoux: Date________ Results _____mm 
Meningitis 1.________ 2.________ Menactra Varicella vaccine 1.________ 2.________ 

MANDATORY for All Nursing and Health Professions ONLY 

MMR and Hepatitis B requirements as above. 
Td / Tdap (circle one) Date of last Booster: (must be within 10 years) Date: __________ 
Varicella (Chicken pox) IgG blood test (titer): _______ (Copy of lab report must be attached) 
OR Varivax Dose#1 _______ Dose#2 _______ (4 to 6 weeks apart) (Varivax required if titer is negative) 
TB test: PPD skin test OR Q-Gold blood test date within 6 months of starting program: PPD results Neg ( ) Pos _____mm. 
If PPD or Q-Gold result is positive, Chest x-ray required within 1 yr. of starting program. Copy of Q-Gold lab report is required. 
Name of Health/Medical Insurance Company/Group and Address _______________________________________________________________ 
Ppolicy or Group #________ expiration date________ (copy of card must be attached) 

Signature: Health Care Professional/Physician Stamp/Address Date __________
NOTE: NURSING AND HEALTH PROFESSIONS STUDENTS ONLY:  
THIS MEDICAL EXAM MUST BE RETURNED TO HEALTH SERVICES BEFORE STARTING CLASSES IN ORDER TO 
BE CLEARED FOR CLINICAL. MEDICAL EXAM MUST BE DATED WITHIN 6 MONTHS OF STARTING YOUR 
PROGRAM

ID#___________________
Email Address: _______________________________

BCC HEALTH SERVICES MEDICAL RECORD
OFFICE: 201-447-9257  FAX 201-447-0327

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: ________ Respiration: ________ Temp: ________

Allergies: ____________________ Medications: ____________________

General Appearance: _______________________________________________________________________________________

Review of Systems: ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Skin (acne, fungus infection) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Head/Neck (masses, range of motion, pain on motion) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Glands (cervical, axillary, inguinal) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Eyes (conjunctiva, jaundice) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Ears (infection, perforation, hearing) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Nose (obstruction) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Mouth/Teeth/Throat ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Chest ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Lungs (chronic bronchitis, asthma) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Heart (murmurs, click, rhythm) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Abdomen (Liver, spleen, masses) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Back (deformity, range of motion, scoliosis) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Extremities (range of motion, deformity, weakness, scars) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Neurological (reflexes, balance, coordination) ____________________ Norm Abnor ____________________ Comments/ Description ____________________

Clinical Impression based on history and physical exam: ____________________

Recommendations: For this student:

_____ May participate in physical activities

_____ Needs health problems evaluated prior to participation in physical activities

_____ Health problem limits participation in physical activities: ____________________

_____ Limit classroom and physical activities as follows: ____________________

Comments or Recommendations: ____________________

_______________________________________________________________________________________________

____________________________________________________

Signature: Health Care Professional/Physician: ____________________ Date: __________

Health Care Address Stamp

Rev 4/13
Incoming Nursing/Health Professions Students – Tuberculosis (TB) Screening Requirement

**Part A** must be completed by you. **Part B** must be completed by your physician or healthcare provider. Please return the completed form to The Office of Health Services, HS-100, Pitkin Education Center.

**Part A**

Name: ____________________________________________ Date of birth: ______________

Student ID: __________________________ Email address: _________________________________

Home Phone: ___________________________ Cell Phone: _______________________________

**Part B**

**Tuberculosis (TB) Screening:** In order to be cleared for clinical participation, you are required to submit the date and results of either a **PPD skin test** OR an interferon gamma release assay (IGRA) blood test such as **Quantiferon Gold.**

* **A 2-Step PPD skin test is necessary unless a PPD was done within the past calendar year.** * If a 1-Step PPD was done within the past calendar year, documentation must be entered below. If an annual PPD was missed, a 2-Step PPD skin test must be done within 6 months of starting your program.

PPD(Mantoux) #1: _________ (date administered) _________ (date read- 48-72 hrs. after injection)

Results: positive _________ negative (circle one); report positive results in millimeters.

PPD(Mantoux)#2: _________ (date administered) _________ (date read- 48-72 hrs. after injection)

Results: positive _________ negative (circle one); report positive results in millimeters.

OR

**Quantiferon Gold blood test may be used in place of PPD – Lab report must be attached**

__________ (date of test) Result: positive negative (circle one)

**Chest X-ray is required if PPD or Q-Gold result is positive. Chest X-ray must be performed within 6 months of starting program. Chest X-ray report must be attached.**

If result of the Q-Gold blood test is indeterminate, repeat Q-Gold or administer PPD skin test.

Signature of physician or healthcare provider: ____________________________ Date: __________

Healthcare Address Stamp: Rev 4/13
CPR CERTIFICATION

ALL NURSING STUDENTS ARE REQUIRED TO MAINTAIN CPR CERTIFICATION FROM THE FOLLOWING ORGANIZATIONS ONLY:

American Heart Association
BLS for Health Care Provider Certification

OR

American Red Cross
CPR/AED for the Professional Rescuer and the Healthcare Provider Certification

A photo copy of your CPR Certification card must be submitted to the Nursing Office Secretary – Room B-302

Proof of completion of a live course must be submitted to the Nursing Department Secretary by the deadline. It takes a few weeks to receive your official CPR card. Upon receipt of your card, please make a photo copy of the card and submit the copy to the Nursing Office. Class schedules are available online at the American Heart Association website, www.americanheart.org and the American Red Cross website, www.redcross.org.

Students who are unable to meet the performance criteria for Certification due to health restrictions must:

1. present a physician’s statement excluding them from this requirement and
2. attend the theory component of the CPR course.

Proof of exemption must be sent directly to the Nursing Dept. office, Room B-302, from the physician; attendance at the course must be validated.
Bergen Community College – Department of Nursing
Nurse Skills Kit - $125.00

This order form, along with your payment must be received by M&M Medical Sales, Inc. by December 18, 2013. Orders received after this time will not be guaranteed for pick up at the designated time.

Due to FDA regulations, once you receive your Nurse Skills Kit, it cannot be returned. The contents of this Kit have been developed in conjunction with your instructors and are required for your program.

*Payment is accepted by Cash, Certified check, or Money Order only.*

All orders must be mailed to:

M&M Medical Sales, Inc.
356 Maple Avenue
Glen Rock, New Jersey  07452

by December 18, 2013

Please include the following information:

Student’s Name:________________________________________________________

Telephone Number: ________________________________________________

PLEASE RETURN THE ENTIRE ORDER FORM
The Nurse Skills Kit is a custom package, which will be made to order for you. *If you do not order before the deadline, M&M Medical Sales cannot guarantee the availability of a Nurse Skills Kit for you.*
Dear Level One Student:

Welcome to the Nursing Program at Bergen Community College. We have a proud 40+ year history of educating nurses to provide health care to area residents and beyond. The faculty and nursing administration rigorously and regularly reviews student and program outcomes always seeking new ways to improve the teaching/learning process. As a result of our studies, we are so pleased to introduce a program to further aid nursing students to learn the theory and clinical application of theory to nursing practice.

This program is an extension of our long affiliation with ELSEVIER/EVOLVE REACH testing and remediation. You may recognize the name because the entrance examination you took to qualify for the Nursing Program is an EVOLVE product. The program, utilized by numerous nursing programs throughout the country, will include the following products:

- Practice Tests and Case Studies
- Patient Reviews
- Assessment examinations to be offered at the end of each course

This program will provide YOU with personalized electronic remediation content; it will help you address your weaknesses. Your performance will be assessed in accordance with the categories tested on the HESI exit examination AND the national licensing examination, (NCLEX-RN) that you will be required to take to become a registered nurse.

We wish you the very best and will share in your success as you achieve your goal of becoming a registered nurse.

*Dawn Kozlowski PhD, RN, CNE*  
*Associate Dean of Nursing*

**Pick up ACCESS KEY CODE: January 7, 2014 at Nursing Orientation**

**Complete online Evolve registration by: January 14, 2014 – no exceptions.**
NURSING STUDENT SCHOLARSHIPS

There are many scholarships available for students enrolled in the Nursing Program at Bergen Community College. We encourage all students to take advantage of the financial assistance offered by the scholarships available at BCC. Nursing student scholarships and the application can be viewed on the Bergen Community College web page via the following link:

http://www.bergen.edu/pages/1817.asp

Please see the links for complete information related to nursing student scholarships. Following is a partial list of scholarships available to BCC nursing students:

- **Nick Anagnostakos Endowed Nursing Scholarship Fund**
  Provides an annual award for a nursing student exhibiting excellent academic achievement and financial need.

- **Dorothy P. Romaine Evening Nursing Scholarship**
  This award will be given to a duly enrolled evening nursing student with a demonstrated financial need who has completed sixteen (16) credits in their program with a 3.0 or greater G.P.A. In addition, the recipient will be an independent and critical thinker who has demonstrated maturity.

- **Denise Roswell Nursing Scholarship**
  Provides an award for a female nursing student with one or more children who has returned to college to complete her degree; maintains a GPA of 3.0 or more; has completed one half of the nursing program, has a financial need and exhibits clinical experience as documented by her instructors.

- **William M. Orr Endowed Scholarship**
  Provides annual scholarship awards for students who have completed at least one semester in the nursing program, have demonstrated good clinical skills, have a GPA of 3.0 or greater, exhibit the characteristics of an independent and critical thinker and has demonstrated maturity.

- **Maura Soehnlein Memorial Scholarship**
  Provides an annual scholarship award, preferably for a parent with a demonstrated financial need, who has completed at least one semester in the nursing program with good grades, has demonstrated good clinical skills, has a GPA of 3.0 or greater, and is a warm, caring, loving person who wants to help others.

- **Dr. Audrey Stephan Endowed Nursing Scholarship**
  This fund, named in memory of longtime nursing faculty member, Dr. Audrey Stephan, provides an award for an evening nursing student exhibiting financial need, dedication to the field of nursing and a GPA of 2.75 or greater.

- **Theresa Romano Nursing Scholarship**
  Provides an award for a full- or part-time nursing student (although the award may be offered to a student in one of the Allied Health programs) who has completed one full semester, has a cumulative GPA of 3.0 or greater, and is not on financial aid but exhibits financial need.

- **Ellen Fressola Scholarship for Nursing**
  Provides an annual award for a student who has completed two semesters in the nursing program, is a single parent (male or female) and has a GPA of 3.5 or greater.

- **Marian "Mona" Dolecki Endowed Scholarship Fund**
  Provides an annual scholarship award for a nursing student who has completed Nursing II and has a financial need.
BERGEN COMMUNITY NURSING PROGRAM

Mr.  Mrs.
FULL NAME:  Ms.  Miss:  ______________________ PHONE #:  ______________________

ADDRESS:  _________________________________________________________________

CITY:  __________________ STATE:  ___________ ZIP:  ___________ APT#  ___________

PANTSUIT w/ emblem

sz _____ ( ) @ $54.00 ea.  $ ____________

NAME PIN

sz _____ ( ) @ $ 7.00 ea.  $ ____________

BANDAGE SCISSORS

( ) @ $ 5.00 ea.  $ ____________

WARM-UP JACKET w/ emblem

sz _____ ( ) @ $23.00 ea.  $ ____________

MENS TUNIC w/ emblem

sz _____ ( ) @ $25.00 ea.  $ ____________

MENS SLAX

sz _____ ( ) @ $21.00 ea.  $ ____________

MENS WARMUP JACKET

sz ______ ( ) @$26.00 ea.  $ ____________

* MINIMUM 2 GARMENTS IN ANY COMBINATION *

WARM-UP JACKET OPTIONAL

OTHER ITEMS AVAILABLE

SHOES  style ______ sz ______ ( ) @ $ ea.  $ ____________

STETHOSCOPE KIT  color ______ ( ) @ $30.00 ea.  $ ____________

WATCHES

( ) @ $ ea.  $ ____________

Shipping Charge  $ ____________

CASH * MONEY ORDER * CREDIT CARD  $ ____________

TOTAL

* PAYMENT AT TIME OF FITTING *

AMOUNT PAID  $ ____________

BALANCE  $ ____________

FITTING HOURS: Monday thru Saturday 10:00a.m. to 5:00p.m.  NO APPOINTMENT NEEDED

PANTSUIT:  tunic size  ____________  alter tunic  ____________

slax size  ____________  alter slax  ____________
Textbooks
Fall 2013 and Spring 2014

NUR 181 - Assessment

or

NUR 182 - Pharmacology / Math


NUR 183 – Concepts

or


Optional


Nursing Care Plan Books - student choice

