RUTGERS
CAMDEN

Department of Nursing
Armitage Hall, Room 407
College of Arts and Sciences
Rutgers, The State University of New Jersey
311 North 5th Street
Camden, NJ 08102-1405

http://nursing.camden.rutgers.edu
nursecam@camden.rutgers.edu

Phone: 856-225-6226
Fax: 856-225-6250

APPLICATION FOR THE RN to BSN PROGRAM

PLEASE PRINT CLEARLY

NAME: ____

ADDRESS: ____

____

Please check Campus you wish to attend:

Rutgers Camden: _____ **Atlantic Cape Community College:** _____

Camden County College at Blackwood: _____

Home Phone: ________.________.____________ **Cell Phone:** _______.________.______________

E-mail:______________________________ **RUID:** ______________________________

Gender (Optional): _______ **Race (Optional):**____________________

NJ Nursing License Number: ______________________________ **Year Received:** ______________

NOTE:

1. To be eligible for admission to the RN to BSN program at Rutgers Camden College of Arts & Sciences, Rutgers at Atlantic Cape Community College, or Camden County College at Blackwood you must be a RN and have taken and passed the NCLEX exam.
2. You must fill out and return this form in addition to completing and submitting the Rutgers online application at www.admissions.rutgers.edu .
3. If you have any questions about this form or the program, please contact Laurie Davis, Coordinator of RN to BSN program at Rutgers Camden and Camden County College at Blackwood, at nursecam@camden.rutgers.edu or Nancy Powell, Coordinator of the Atlantic Cape Community College RN to BSN program at nmpowell@camden.rutgers.edu.
4. Sign, date and return this form to:

Dept. of Nursing, Rutgers Camden College of Arts & Sciences
311 N. 5th Street Armitage Hall Room 407, Camden, NJ 08102
Phone: 856-225-6226
Fax: 856-225-6250
Email: nursecam@camden.rutgers.edu

Signature of applicant: ______________________________ **Date:** ______________

Department Approval: ____

Department of Nursing
Armitage Hall, Room 407
College of Arts and Sciences
Rutgers, The State University of New Jersey
311 North 5th Street
Camden, NJ 08102-1405

http://nursing.camden.rutgers.edu
nursecam@camden.rutgers.edu

Phone: 856-225-6226
Fax: 856-225-6250

STUDENT HEALTH RECORDS PACKET

Attached is your "**Health Records**" packet, which Rutgers University, Camden College of Arts & Sciences, Department of Nursing requires to be completed in order to be enrolled in the college and in the Nursing Program. **Please note that you cannot attend clinical experiences** if your health records are incomplete or not on file in the *Student Health Services* office on the Camden Campus.

These health forms are to be returned to **Health Services – Camden Campus** prior to the beginning of classes; for Fall semester by 08/18/2011 or Spring semester by 01/10/2012. You are encouraged to complete these requirements as soon as possible due to the amount of time involved in obtaining Rubella titers and scheduling immunizations. All nursing students are required to have annual PPD (TB) testing. We encouraged you to visit Health Services to complete your physical examination requirements (they are currently offering a reduced rate of $25 per doctors visit for transfer students, all other students are free of charge for the office visit, other fees will apply), please visit their website at http://healthservices.camden.rutgers.edu or call them at 856-225-6005 to schedule an appointment.

Please submit all health record forms even though you may be receiving the Hep B injection series (the series must be completed before the end of the Fall 2011 semester).

Females encouraged to have PAP testing every 12 months.

PLEASE RETURN YOUR COMPLETED HEALTH RECORDS TO:

Rutgers University
Health Services
326 Penn Street, 2nd Floor
Camden, NJ 08102
856-225-6005

RUTGERS
CAMDEN

Department of Nursing
Armitage Hall, Room 407
College of Arts and Sciences
Rutgers, The State University of New Jersey
311 North 5th Street
Camden, NJ 08102-1405

http://nursing.camden.rutgers.edu
nursecam@camden.rutgers.edu

Phone: 856-225-6226
Fax: 856-225-6250

IMMUNIZATION RECORD

Name____ SOC. SEC. #_____ ____ _____
Last First Middle

<u>This section should be completed by the student's health care provider</u>
PLEASE PROVIDE ALL OF THE NECESSARY INFORMATION BELOW AND SIGN:

A. MEASLES, MUMPS, RUBELLA **(2 doses or the equivalent are required)**
Date student received live virus vaccine Must be after 1 year of age
Date of injection must be after 1980

**RUBEOLA (Measles) _____/_____/_____
**RUBELLA (German Measles) _____ /_____/_____
**MUMPS ____ /_____/_____

**MMR vaccine may be substituted for measles/mumps/ rubella vaccinations
MMR1 _____/____ /_____
MMR2 _____/____/______

B. VARICELLA (2 doses more than 1 month apart): _____/_____/_____ _____/_____/_____
If had disease - titer is required

C. TETANUS Dates of initial series and boosters (the last booster must be within 10 years) Date of Last Booster
_____/_____/_____, _____/_____/_____, ____/____ /_____, ____ / ____/_____ _____/______/______

D. POLIO Dates of initial series and boosters (must have had one booster) Date of Last Booster
_____/_____/_____, _____/_____/_____, ____/____ /_____, ____ /_____/_____ _____/_____ /________

E. TUBERCULOSIS (Mantoux test (2 step test unless evidence of previous 2 step is presented)

#1. Mantoux test (Annual Test Unless Positive) Date & Place______ Result_______ MM Induration______
Date Read_____________
#2. Mantoux test (Annual Test Unless Positive) Date & Place______ Result_______ MM Induration_______
Date Read___________
Positive Mantoux Result Follow-up: CXR (Date) _____ Result_____ Preventative Rx_____ Duration____
Date Initiated__________
Preventative Rx: None______ Rx_______________ Dates of Rx____________________

F. HEPATITIS B Vaccine* Date of 1st Vaccine _____/_____/_____ Date of 2nd vaccine _____/_____/_____ Date of 3rd vaccine _____/_____/_____

*Completion of series required before end of first academic year. Available from your private physician, Student Health Service, or Employee Health Service.

G. MENINGOCOCCAL ____ /_____/_____

H. Flu Vaccine: Must be completed by November 15, 2011 (Flu vaccine is mandatory unless indicated by doctor).

RUTGERS
CAMDEN

Department of Nursing
Armitage Hall, Room 407
College of Arts and Sciences
Rutgers, The State University of New Jersey
311 North 5th Street
Camden, NJ 08102-1405

http://nursing.camden.rutgers.edu
nursecam@camden.rutgers.edu

Phone: 856-225-6226
Fax: 856-225-6250

Laboratory Results

______________________________ Social Security #: ______________________

Last Name ***First Middle***

IMMUNE SEROLOGY TITERS:

(A copy of each laboratory test must be attached.)

1. Rubella
2. Rubeola
3. Mumps
4. Varicella
5. Hepatitis B Surface Antibody (**4 to 8 weeks after 3 injections**)

Health Care Provider Name and Degree: ______________________________

Address: ______________________________

____

Provider's Signature: ______________________________

Date: ______________________________

- -

Health Insurance: In addition to the university-sponsored insurance, the student has the following insurance:

Blue Cross: ☐ Blue Shield: ☐ Medicaid: ☐

Rider J: ☐ HMO: ☐ Other: ☐

Subscriber's Name: Policy/Groups Nos.:
____

Name & Address of Employer: ______________________________

____

Name & Address of Insurance Co.: ______________________________

____

Revised: October 2007

RUTGERS
CAMDEN

Department of Nursing
Armitage Hall, Room 407
College of Arts and Sciences
Rutgers, The State University of New Jersey
311 North 5th Street
Camden, NJ 08102-1405

http://nursing.camden.rutgers.edu
nursecam@camden.rutgers.edu

Phone: 856-225-6226
Fax: 856-225-6250

Physical Examination

NAME_______________________________________ SOCIAL SECURITY#____________________________

Permanent Mailing Address ____

Telephone # ____________________ Sex: Male_____ Female_____ Date of Birth____________

PHYSICAL EXAMINATION REPORT – (Complete All Items)

Height___________ Weight___________ Blood Pressure_________________ Pulse___________

Vision: with correction R 20/__________ L 20/___________ Hearing Rt_______ Lt_______
without R 20/__________ L 20/___________

	Normal	Abnormal	Description
Appearance			
Nutrition			
Skin (acne, fungus infection)			
Head/Neck (masses, range of motion, pain on motion)			
Glands (cervical, axillary, inguinal)			
Eyes (conjunctiva, jaundice)			
Ears (infection, perforation)			
Nose (obstruction), Throat			
Mouth/Teeth			
Chest			
Lungs (chronic bronchitis)			
Heart (murmurs, clicks, rhythm)			
Abdomen (liver, spleen, masses)			
Back (deformity, range of motion, scoliosis)			
Extremities (joint mobility, instability, deformity, muscle weakness, atrophy, scars)			
Testes (presence, descent, masses)			
Genitalia/Pelvic (Pap for women recommended) **date**			
Neurological (reflexes, balance, coordination)			

Findings: Able to function in clinical classes with the following restrictions ________________________________

____

Examiner's Name & Degree (please print): ____
Address: ____
____

Signature: ___________________________________ Date: ____________________

Revised: October 2007