Northern Marianas College
Health Evaluation Form

Rev. 6.28.2021

Submit completed form to the Office of Admissions & Records **before registration**.
P.O. Box 501250 • Saipan, MP 96950
As Terlaje Campus, Bldg. N
Phone: 670-237-6769 or 6770 or 6771
Email: oar@marianas.edu

Please print or type when completing this form. **Do not use a pencil.**

Part 1: To be completed by the student

LAST NAME	FIRST NAME	M.I.

MAILING ADDRESS	APT#	CITY	STATE	ZIP

DATE OF BIRTH (MM/DD/YYYY)	DAY PHONE	EMAIL ADDRESS

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Northern Marianas College requires all admission applicants to submit a completed Health Evaluation Form. This requirement is intended to lower rates of vaccine-preventable diseases among individual students and outbreaks within the campus community.

Part 2: Immunization History. To be completed by a Health Care Provider. Signature and stamp required.

	Month/Day/Year
MMR (Measles, Mumps, Rubella) If given instead of individual immunization	
Date of **1st** vaccine (12 months after birth or later, AND on or after January 1, 1972)	____/____/____
Date of **2nd** vaccine (15 months after birth or later, AND at least 28 days after 1st vaccine)	____/____/____
or attach copy of Positive lab results for MMR titers	
Tdap (Tetanus, diphtheria, cellular pertussis)	
Date of one dose of vaccine given within the past ten (10) years.	____/____/____
Hepatitis B	
Date of **1st** dose of vaccine	____/____/____
Date of **2nd** dose of vaccine (at least one month after after the first dose)	____/____/____
Date of **3rd** dose of vaccine (at least two months after after the second dose and four months after the first dose)	____/____/____

COVID-19 Vaccination

Vaccine	Product Name/Manufacturer/Lot Number	
1st dose vaccine	_____	____/____/____
2nd dose vaccine	_____	____/____/____
Other	_____	____/____/____
Other	_____	____/____/____

Medical Exemption: Student has a medical condition that prevents them from receiving the _____ vaccine(s).

Name of Licensed Physician	Signature of Licensed Physician

Part 3: Tuberculosis TB Screening. To be completed by a Health Care Provider. Signature and stamp required. NMC requires all applicants to undergo TB screening prior to matriculation. All ongoing students are required to complete TB screening annually and must do so prior to the start of the fall term. All students who report a prior history of TB skin test positive must undergo a symptom survey and attestation form annually. If a student is found to have active TB, that student must agree to treatment and subsequently cleared by a health care provider prior to returning to NMC. All applicants with a prior history of BCG vaccination must obtain a chest x-ray and be cleared by a health care provider to matriculate.

	Month/Day/Year	Results
Date of TB skin test	____/____/____	Positive or Negative
Chest X-Ray (required if TB skin test is positive)	____/____/____	Latent or Active

Include official stamp (In English)

Signature of Health Care Provider	Date