



NORTHERN MARIANAS COLLEGE
Office of Admissions and Records (OAR)
 P. O. Box 501250 ~ Saipan, MP 96950
 Phone: (670) 234-5498 ext:1523/28/39 ~ Fax: (670) 235-4967
 E-mail: oar@nmcnet.edu

**HEALTH
EVALUATION
FORM**

The Northern Marianas College requires all applicants to submit a completed Medical History Evaluation report (Public Law 3-4 Chapter VI, Section 6 and 602). Your student health record is solely for the internal use of the Student Services Office and will not be disclosed to anyone without your consent.

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

1. Name: _____ 2. Gender: ___ Male ___ Female
 3. Mailing Address: _____

	Yes	No	Comments
4. Do you have allergies to food or medicine?			
5. Do you have any chronic or serious illnesses ?			
6. Are you on any prescribed medication?			

IMMUNIZATION HISTORY

Note: You must bring medical records (in English) for every "Yes" response

Measles	9. I had measles.	Yes No	Date: / /		
	10. I had the measles vaccine.	Yes No	Date: / /		
PPD	11. I have/had tuberculosis.	Yes No	Date: / /		Result:
	12. I had a PPD skin test.	Yes No	Date: / /		Result:
	13. I had a Chest X-Ray.	Yes No	Date: / /		
Tetanus	14. I had the tetanus vaccine.	Yes No	Date: / /		
Hepatitis B	15. I have Hepatitis B.	Yes No	Date: / /		
	16. I had the Hepatitis B vaccine.	Yes No	Date #1: ____ / ____ / ____.		
			Date #2: ____ / ____ / ____.		
			Date #3: ____ / ____ / ____.		

NON-DISCRIMINATION CLAUSE

The Northern Marianas College's admissions process does not discriminate on the basis of race, gender, national or ethnic origin, age, religion or disability. In compliance with the Title II of the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, NMC offers access and equal opportunities in its admission policies, academic programs and services, and employment to students with disabilities in that no otherwise qualified person will be denied of these provisions on the basis of disability.

In signing this form, I certify that I have read the Non-discrimination Clause above.			
I also certify that all the information given above is true and correct to the best of my knowledge.			
17. _____	_____	18. _____	_____
Student's Signature	Date	Doctor Acknowledge Review	Date