Northern Marianas College
Health Evaluation Form

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

Part 1: To be completed by the student

LAST NAME __________________________ FIRST NAME __________________________ M.I. __________

MAILING ADDRESS ______________________________________________________ rival# __________________________ CITY __________________________ STATE __________________________ ZIP ________

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

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

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 the first dose) ___ / ___ / ___

Date of 3rd dose of vaccine (at least two months after the second dose and four months after the first dose) ___ / ___ / ___

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.

Date of TB skin test ___ / ___ / ___ Results 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 ___________