NHTI Health & Counseling Services
Physical Exam Form

31 College Drive
Concord, NH 03301-7412
nhtihealthservices@ccsnh.edu
TEL (603) 230-4043 FAX (603) 230-9308

Student Name: _____ Date of Birth_____

Date of Physical Exam _____ (within 12 months of admission)

Height_____
Weight_____
BP _____ Pulse _____
Eyes _____
Glasses/ Contacts _____
Last eye exam _____
Visual Acuity – (L) OS_____ (R) OD _____ OU_____
Ears_____
Hearing: Right_____ Left_____
Females: Menses: Frequency _____
Duration _____
Issues _____

Throat and mouth_____
Thyroid_____
Skin _____
Heart_____
Lungs_____
Abdomen_____
Orthopaedic_____
Spine_____
Feet_____
Joints_____
Extremities_____

If student is under a healthcare provider's continuing care for any reason, including mental health, a summary from the healthcare provider regarding her/his treatment and medications must be included.

By signing this page, I acknowledge that I have examined the student and they may participate in all normal college activities including intercollegiate sports, clinical rotations and may live independently on campus unless otherwise noted.

Healthcare Provider Signature:_____

Please print name: _____

Address: _____ Date_____ Phone_____

*Please sign page 2 or attach immunizations

Student Name _____ **D.O.B.**_____

RESIDENCE LIFE or SPORTS IMMUNIZATION REQUIREMENTS

MMR (both given after 1980)
MMR 1:
(mm/dd/yyyy)
MMR 2:
(mm/dd/yyyy)

OR

MMR Titer	
Measles Titer:	**CIRCLE ONE**: positive or negative
(mm/dd/yyyy)	
Mumps Titer:	**CIRCLE ONE**: positive or negative
(mm/dd/yyyy)	
Rubella Titer:	**CIRCLE ONE**: positive or negative
(mm/dd/yyyy)	

TDAP:
TDAP
(mm/dd/yyyy)

OR

Tetanus
Td
(mm/dd/yyyy)

If you are planning on participating in sports, you are required to attach a copy of your insurance.

******** **Name of Provider completing form**: _____ ********