Health Services

Phone: 603-230-4043 (press 1 for Health Services)
Fax: 603-230-9308
Email: NHTIhealthservices@ccsnh.edu

Dear Healthcare Provider:

We are sending this letter along with our immunization form, as there has been confusion in the past regarding what we require to clear NHTI students to attend clinical rotations.

In particular, these **three things tend to be missed**, but they are required:

1. Hepatitis B surface antibody titer (even if the student has had the full hepatitis B series)
2. Varicella shots or titer, even if the student had the disease
3. Either a 2-step TB test or TB blood work (T-spot or Interferon Gold) **administered this year**

Please be sure to read the immunization form and let us know if you have questions: 603-230-4043 and press '1' for Health Services.

Thank you!

Janet Ercolini RN, BSN, MS
Director of Health Services
NHTI - Concord's Community College
Office: 603 230-4043 #1
Direct: 603-271-6484 ext. 4330
Fax: 603-230-9308

Health Services

P: 603-230-4043
F: 603-230-9308
NHTIhealthservices@ccsnh.edu

Physical Exam Form

Student name _____ **Date of birth** _____

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

Height _____
Weight _____
BP _____
Eyes _____
Glasses/contacts _____
Last eye exam _____
Visual acuity (L) OS _____ (R) OD _____ OU _____
Ears _____
Hearing—right _____
Hearing—left _____
Menses (females only) _____
Frequency _____
Duration _____
Issues _____

Throat/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 and clinical rotations, and may live independently on campus unless otherwise noted.

Healthcare provider signature _____

Healthcare provider print name _____

Address _____ Date _____ Phone _____

Health Services

P: 603-230-4043
F: 603-230-9308
NHTIhealthservices@ccsnh.edu

Allied Health Immunization Requirements

All immunizations are required unless stated otherwise. Please read and fill form out completely. Write vaccination dates (mm/dd/yyyy) in the space provided.

Student name _____ **Date of birth** _____

MMR (both given after 1980)

MMR 1 _____

MMR 2 _____

OR

MMR Titers

Measles Titer _____ Positive or Negative

Mumps Titer _____ Positive or Negative

Rubella Titer _____ Positive or Negative

Hepatitis B Series (titer is required)

Hepatitis B 1 _____

Hepatitis B 2 _____

Hepatitis B 3 _____

Hepatitis B Titer _____ Positive or Negative

2nd Hepatitis B Series (only required if titer is negative)

Hepatitis B 4 _____

Hepatitis B 5 _____

Hepatitis B 6 _____

Hepatitis B Titer _____ Positive or Negative

Tuberculin Skin Test (TST)

TB Test 1

- Given _____
- Read _____
- Read in mms _____

TB Test 2

- Given _____
- Read _____
- Read in mms _____

***If TST test is positive, a blood test is required.**

OR

T-Spot or Interferon Gold

IGRA _____ Positive or Negative

***Attach treatment plan, if applicable.**

 Provider Initials: _____

Tetanus (history of TDAP required)

TDAP _____

Tetanus (required if date is more recent than TDAP)

TD _____

Varicella

Varicella 1 _____

Varicella 2 _____

OR

Varicella Titer

Varicella Titer _____ Positive or Negative

COVID-19

COVID Vaccine 1	Brand	_____	Date Administered	_____
COVID Vaccine 2	Brand	_____	Date Administered	_____
Booster (if applicable)	Brand	_____	Date Administered	_____
Booster (if applicable)	Brand	_____	Date Administered	_____

Name of Provider Completing Form _____