NHTI Health & Counseling Services
Physical Exam Form

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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.**_____

ALLIED HEALTH IMMUNIZATION REQUIREMENTS

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

OR

MMR Titers
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)

Hepatitis B Series – TITER IS REQUIRED
Hepatitis B #1:
(mm/dd/yyyy)
Hepatitis B #2:
(mm/dd/yyyy)
Hepatitis B #3:
(mm/dd/yyyy)
Hepatitis B Antibody Titer:
(mm/dd/yyyy)
CIRCLE ONE: positive or negative

2nd HepB Series w/Titer if 1st titer is NEGATIVE
Hepatitis B #4:
(mm/dd/yyyy)
Hepatitis B #5:
(mm/dd/yyyy)
Hepatitis B #6:
(mm/dd/yyyy)
Hepatitis B 2nd Antibody Titer:
(mm/dd/yyyy)
CIRCLE ONE: positive or negative

Tuberculin Skin Test (TST)
TB Test #1: Date given
(mm/dd/yyyy)
Date read
(mm/dd/yyyy)
Results in mms:
TB Test #2: Date given
(mm/dd/yyyy)
Date read
(mm/dd/yyyy)
Results in mms:
***If TST test is positive, a blood test is REQUIRED.**

OR

T-Spot or Interferon Gold
IGRA:
(mm/dd/yyyy)
CIRCLE ONE: positive or negative
***Attach treatment plan if applicable.**

TDAP: (required)
TDAP
(mm/dd/yyyy)

Tetanus: (required if this is more recent than TDAP)
Td
(mm/dd/yyyy)

Varicella
***Varicella 1:**
(mm/dd/yyyy)
***Varicella 2:**
(mm/dd/yyyy)

OR

Varicella Titer: **CIRCLE ONE**: positive or negative
Varicella Titer
(mm/dd/yyyy)

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