PRESBYTERIAN COLLEGE

PHYSICAL EXAM AND IMMUNIZATION RECORD

In order to provide adequate and effective health services for our students, all students taking courses on campus are required to have on file a record of a physical examination and immunizations.
All forms are to be submitted prior to July 15 for fall enrollment and December 1 for spring enrollment.
Students are not considered to be enrolled until immunization requirements are met.
Please mail this form to Orientation, Presbyterian College,
503 S. Broad St., Clinton, SC, 29325; fax it to 864-833-8516; or email it to orientation@presby.edu.

A. TO BE COMPLETED BY THE STUDENT:

Student's Full Name _____
First Middle Last

Date of Birth _____/_____/_____ Sex _____ Year entering PC 20_____ Freshman? _____ Transfer Student? _____

Email _____ Cell Phone (____) _____ Home Phone (___)_____

Contact Information in the event of an emergency or serious illness:

_____
Name Relationship Best Phone # Email

Family Physician Information (please include name and phone number)

Medical Doctor's Name: _____ Phone_____

Other Provider: _____ Phone: _____

B. REQUIRED IMMUNIZATIONS: THIS SECTION MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

Please list dates of all doses **or** attach a copy of immunization certificate.

VACCINE	Date	Date	Date	Date
DTP, DT, DTP/Hib, DTaP (Diphtheria, Tetanus, Pertussis/Haemophilus Influenzae type B) Given within the last nine years.				
Polio (IPV, oral) Primary series in childhood meets this requirement.				
Hepatitis B Series of three vaccines or positive titer attached.				
MMR (Mumps, Measles, Rubella) Dose 1 given age 12 months or later; Dose 2 given at least one month after first dose. A positive MMR titer may be attached in lieu of vaccination history.				
Varicella (Chicken pox) 2 doses given at least one month apart OR documented clinical history OR a positive titer attached.				
Other				

Meningococcal Vaccine Proof of conjugate meningococcal vaccine given after age 16 Date given: _____
OR a signed waiver declining the vaccine. Waiver: I have read and understand the risk of Meningococcal disease and I am declining to receive the vaccine.
Name _____ Signature _____

Tuberculin Skin Test: (within one year) REQUIRED FOR **ALL** STUDENTS
Date _____ Type _____ Results: Positive _____ Negative _____
Read by: _____

Chest X-ray (required within 1 year of registration if tuberculin test is positive) Date _____ Result _____

C. REPORT OF PHYSICAL EXAMINATION

TO THE EXAMINING PHYSICIAN: The information supplied will not affect the student's status at Presbyterian College; it will be used only as a background for providing health care. This information is strictly for the use of Presbyterian College Health Services.

Student's Name _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

Uncorrected Vision: Corrected Vision: Hearing (gross) :

Right 20/ ——- Left 20/ ——- Right 20/ ——- Left 20/ ——- Right _____ Left _____

Are there any abnormalities of the following systems? Describe fully. Attach sheet if needed.		
	No	Yes, explain
Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		
Is there loss or impaired function of any paired organ?		

Please answer the following: Any explanations or general comments may be listed below or attach a sheet with further information.
Recommendations for physical activity (PE, intramurals, etc.) Limited _____ Unlimited _____
Do you have any recommendations regarding the care of this student? Yes _____ No _____
Is the patient now under treatment for any medical or emotional condition? Yes _____ No_____

Explanations or Comments:

_____

_____

Please list all current medications and dosages	
Medication	Dosage

D. HEALTH CARE PROVIDER SIGNATURE OR STAMP REQUIRED.

Physician's Name (please print) _____ How long have you treated student? _____

Address: _____ Phone Number _____

Signature of Physician _____ Date _____

This information is confidential and will become a part of the student's medical record only. Please notify us if you have any special suggestions regarding the medical management of this student.