PHYSICAL EXAM AND IMMUNIZATION RECORD
FOR
PRESBYTERIAN COLLEGE

In order to provide adequate and effective health services for our students, it is necessary to have on file a record of a physical examination and immunizations for each student. Please be sure to list all dates for each immunization. All information will be considered confidential. This record will be maintained in the Presbyterian College Health/Wellness Services Office. **ALL students must complete this form.**

STUDENT-ATHLETES:

Student-athletes have two separate physical exam forms to complete before arriving at PC.

One from the Orientation Office and another separate one from the Athletic Department. You will need to submit the form below to the Orientation Office, and another separate form, *that is provided to you by the Athletic Department*, to the Athletic Department.

Please have your physician complete the physical exam portion of this form. Any physical exam must have been completed within the past 12 months. **Please mail 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.**

Student's Full Name _____

Preferred Name _____ SS # _____

Date of Birth _____ Sex _____ Year entering PC _____ Freshman or Transfer? _____

Family Physician Information (please include name and contact info):

Family Doctor: _____

_____

Family Dentist: _____

_____

Family Eye care: _____

_____

Contact Information in the event of an emergency or serious illness. Please provide name, relationship to student, and home/work/cell phone numbers.

1. _____

_____

2. _____

_____

REPORT OF PHYSICAL EXAMINATION

TO THE EXAMINING PHYSICIAN: Please complete the two-page physical examination form. The information supplied will not affect his/her status at Presbyterian College; it will be used only as a background for providing health care, when necessary.
This information is strictly for the use of Presbyterian College Health Services and will not be released without student consent.

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 seriously 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, if needed.

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:

_____

_____

Tuberculin Skin Test: (within one year; patch test not accepted)

Date _____ Type _____

Results: Positive _____ Negative _____

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

Date _____ Result _____

Student's Name _____

Please list all current medications and dosages	
Medication	Dosage

If, after this form is completed and forwarded, this student develops any medical problems of any kind, we would deeply appreciate your forwarding us a report so that we may update this health record.

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. Thank you for your cooperation in completing this health record. Please notify us if you have any special suggestions regarding the medical management of this student.

IMMUNIZATION RECORD

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

***As required by SC Law** ****list date of vaccine or dates of chicken pox**

VACCINE	Date	Date	Date	Date
*DTP, DT, DTP/Hib, DTaP—3 doses				
*Polio (IPV, oral) — 3 doses				
*Hepatitis B—3 doses				
*MMR—1 dose				
**Varicella (chicken pox) — 1 dose or positive history				
Meromune (Meningitis)				
Other (Please list)				