

**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. **Please note that this form is in addition to information provided for student athletes to the athletic office.**

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.**

Consent of medical care must be signed for treatment in the Health/Wellness Services office. Please complete page two with current insurance information or attach a copy of a current insurance card. Students are required to provide proof of insurance or sign the waiver information included with this form. If forms are not received, students will automatically be enrolled in the student insurance plan and billed at the current rate.

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 Eyecare:

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. _____

**Authorization and Consent
(Required)**

I hereby agree that the attending physician or whomever he/she may designate may undertake treatment, including operation and/or the administration of the necessary anesthesia, in serious or major illnesses or injuries if the undersigned cannot be contacted. I further hereby agree that needed immunizations may be administered. It is further understood and agreed that Student Health Services at Presbyterian College may release any medical information necessary to other physicians, insurance companies, and government agencies that may require such information for treatment.

Signature of student _____ Date _____

Signature of parent or guardian (required if under age 18) _____

Name of Insurance Company and Contact Info:

Policyholder and Relation to Student :

Policy Holder Date of Birth _____

Policy and/or Group Number: _____

Parent/Guardian Notification: I hereby agree that the Student Health Services staff of Presbyterian College will notify my parents/guardian in the event of an emergency or serious illness.

Signature of student _____ Date _____

Student Insurance Waiver

(to be completed if student does not wish to purchase the PC student health insurance plan)

I will not be joining the Presbyterian College sponsored student health insurance plan. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at the school and that the school will not be responsible for any medical expenses with the exception of varsity athletes. I am currently covered under the policy listed above.

Student Name: _____

Student PC ID: _____ Date: _____

Signature of Student: _____

If a student does not have health insurance, Presbyterian College partners with Collegiate Risk (www.collegiaterisk.com) to offer affordable insurance throughout the school year. Please check out their website for further information.

REPORT OF PHYSICAL EXAMINATION

TO THE EXAMINING PHYSICIAN: Please complete the two-page physical examination form. This student has been accepted. The information supplied will not affect his/her status; 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	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	
Hernia	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	
Metabolic/Endocrine	<input type="checkbox"/>	
Neuropsychiatric	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	
Is there loss or seriously impaired function of any paired organ?	<input type="checkbox"/>	

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.				
*Required by SC Law	**list date of vaccine or dates of chicken pox			
<u>VACCINE</u>	<u>Date</u>	<u>Date</u>	<u>Date</u>	<u>Date</u>
*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)				