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All students taking courses on campus are required to complete the following Health Services Mandatory Requirements. This is a checklist to help ensure you complete all required tasks.

Health Services MANDATORY REQUIREMENTS Checklist:

Student Information on PC's Required Medical Records Form
Complete & Up-to-date Vaccination Record on PC's Required Medical Records Form
TB Skin test and results on PC's Required Medical Records Form
Physical Completed by a medical provider on PC's Required Medical Records Form Completed and Signed PC's Authorization and Consent to Treat Form

Completed forms should be submitted to:

Orientation, Presbyterian College 503
S. Broad St.
Clinton, SC, 29325
(fax) 864-833-8516
MedicalForms@presby.edu

All forms are to be submitted by new students **prior to July 15** for fall registration and enrollment. All forms are to be submitted by new students **prior to October 1** for spring registration and enrollment. Students are not considered to be enrolled until ALL requirements are met.

Contact information for Counseling and Health Services:
120 East Calhoun Street
Clinton, SC 29325
Phone: 864-833-8263
Fax: 864-833-8435
MedicalForms@presby.edu

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REQUIRED MEDICAL RECORDS

In order to provide adequate and effective health services for our students as well as ensure the health and safety of our campus community, all students taking courses on campus are required to complete the Required Medical Forms. Students are to complete and submit the Required Medical Records Forms which include a physical examination, TB skin test, and immunizations. An *Authorization and Consent to Treat* form is also required to be completed. All forms are to be submitted by new students prior to July 15 for fall registration and enrollment and December 1 for spring registration and enrollment. Students are not considered enrolled until ALL 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 MedicalForms@presby.edu.

A. STUDENT INFORMATION: *THIS SECTION TO BE COMPLETED BY THE STUDENT*

Student's Full Name _____

First Middle Last

Preferred Name _____ Date of Birth _____/_____/_____ Gender _____

Year entering PC 20_____ Freshman? _____ Transfer Student? _____ International Student? _____

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

Emergency Contact

The Emergency Contact will be notified in the event of an emergency or serious illness when necessary

_____

Name Relationship Phone Number(s)

Care Providers Information

Medical Doctor's Name _____ Phone_____

Specialty _____ City, State _____

Specialist _____ Phone _____

Specialty _____ City, State _____

Other Provider _____ Phone _____

Specialty _____ City, State _____

B. IMMUNIZATION REQUIREMENTS:

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. Blood titers showing positive immunity can be submitted in place of vaccination dates.

Required Vaccines *Series requirement in parenthesis*	Vaccination Dates			
Hepatitis B (3)				
Polio –**IPV/OPV** (3)				
Diphtheria, Tetanus, Pertussis - **DTP, DT, DTaP** (4)				
Varicella (2)				
Meningitis ACWY – **MCV4** (2)				

Recommended if indicated, but NOT required vaccines				
Meningitis B				
HPV				
Hepatitis A				
Influenza				
Pneumococcal				
Booster in the past 10 years Td/Tdap		Check which type of booster:	Td:	Tdap:

C. Tuberculin Screening Test: REQUIRED FOR ALL STUDENTS within one year of admission

******A Chest X-ray will be required if:*** TB skin test (TST,PPD) is positive, Interferon Gamma Release Assay (IGRA) blood test is positive, or if there is a history of BCG (Bacille Calmette-Guerin) and no IGRA was completed.

TB Skin Test: Date Given _____ Date Read _____ Read by _____

Result _____ mm of Induration Interpretation Negative _____ Positive _____ ***

History of **BCG** vaccination? YES_____*** No_____

If history of BCG, was Interferon Gamma Release Assay (IGRA) completed? YES_____ No_____***

IGRA Date Obtained _____ Method: QFT-GIT_____ T-Spot_____ other_____

Chest X-ray Date _____ Result _____ *Please attach copy of physicians report*

Signature of Health Care Provider: _____ Date: _____

D. 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 _____ DOB _____

Height _____ Weight _____ Temp _____ Blood Pressure _____ HR _____ RR _____

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		
Loss / 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:

_____

_____

E. HEALTH CARE PROVIDER SIGNATURE OR STAMP REQUIRED.

Physician's Name (please print) _____

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 specific suggestions regarding the medical management of this student.

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AUTHORIZATION AND CONSENT TO TREAT

Student's full name _____ DOB _____

Consent for treatment and release of information: I (and my parent/guardian, if I am under 18) hereby agree that an emergency medical responder, treating physician or whomever he/she may designate may undertake treatment, including operation and/or the administration of the necessary anesthesia, in case of serious or major illnesses or injuries where I (or, if I am under 18, my parent or guardian) cannot be asked for consent. I (and my parent/guardian, if I am under 18) authorize appropriate employees of Presbyterian College to obtain such treatment on my behalf under those circumstances and to present this consent to treating medical personnel. I (and my parent/guardian, if I am under 18) agree that neither Presbyterian College nor any person acting on its behalf shall be liable for a good-faith decision to obtain medical care for me.

I (and my parent/guardian, if I am under 18) further hereby agree that needed immunizations may be administered, and 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.

College not responsible for costs of treatment: I (and my parent/guardian, if I am under 18) fully understand that I am legally responsible for any medical expenses incurred during my enrollment at Presbyterian College and that the College does not provide insurance and will not be responsible for any medical expenses incurred by me, including but not limited services obtained for me by College personnel. I understand that it is my responsibility to obtain medical insurance, if I should choose to do so.

Signature of student _____ Date signed _____

Signature of parent or guardian _____

Printed name of parent/guardian_____

Parent/Guardian Notification: I hereby agree that a staff member of Presbyterian College may notify my parents/guardian in the event of a medical emergency or serious illness.

Signature of student _____ Date _____