Presbyterian College
Required Medical Form

Presbyterian College REQUIRES the following medical information and immunizations in order to complete registration for classes. **Failure to meet this requirement will result in a hold on your account which will delay your registration.** This applies to all undergraduate students, including transfers.

You may be able to obtain your records from your healthcare provider, local health department, or high school. Transfers may be able to obtain them from their former college/university. You may also have a personal copy of your healthcare certificate. Each record must be signed by your local physican's office or have the health department signature/stamp. Blood titers showing positive immunity can be submitted in place of vaccination dates.

Please make a copy for yourself prior to returning this form by mail (Counseling Services - Alumni House, Presbyterian College, 506 South Broad St., Clinton, SC, 29325), fax (864-833-8435), or email (MedicalForms@presby.edu).

Student's Full Name _____

Date of Birth _____ Student ID Number _____

Check One: New Freshman ☐ Transfer ☐ International Student ☐

Athlete? Yes ☐ No ☐ (Does not include high school or intramural sports)

ATHLETES ARE REQUIRED TO FILL OUT THIS FORM IN ADDITION TO THE FORMS REQUIRED BY ATHLETICS.

REQUIRED VACCINES: *Please include dates or attach an official copy*			
MMR (2 doses)			
Hepatitis B (3 doses)			
IPV/OPV (polio-3 doses)			
TD/TDAP Booster (date within last 10 years)			
Varicella (2 doses)			
Meningitis ACWY (2 doses) *			

* Two doses are required if the first dose is prior to age 16. Only one dose is required if first dose is age 16 or older.

Signature of Physician or
Health Dept. Official: _____ Date _____

MENINGOCOCCAL VACCINE WAIVER:
I have read the CDC.gov recommendations and understand the risk of the Meningococcal disease and I am declining to receive the vaccine.

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

* A Parent/Legal Guardian's Signature is required for students under the age of 18 to decline this vaccination.

Student Name _____ ID _____

Recommended, but NOT REQUIRED vaccines:	Dates of Vaccination(s)		
HPV (2-3 doses)			
Meningitis B (2 doses)			
Hepatitis A (2 doses)			
Influenza (1 dose)			
Pneumococcal (1 dose)			
COVID-19 Vaccine	Dates of Vaccination(s) *Please fill-in dates for type of vaccination received:*		
Pfizer-BioNTech: (ages ≥16 years) (2 Doses)			
Moderna: (ages ≥18 years) (2 Doses)			
Janssen: (ages ≥18 years)			

https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html

Tuberculosis Screening Questionnaire: (check one)	Yes	No
Have you lived in, traveled to, or had household visitors from Asia, Africa, South America, Central America, the Caribbean, Eastern Europe, or the former Soviet Union with in the past 5 years?		
Have you had close contact with person(s) known to have or suspected of having tuberculosis?		
Have you ever had a positive TB Skin Test?		
Have you worked/volunteered in or been a resident of a long-term care facility, nursing home, homeless shelter, correctional institution, hospital or other healthcare facility, or residential facility for persons with AIDS?		
Do you have any of the following conditions: diabetes, renal failure or dialysis, leukemia or lymphoma, other cancer, immunosuppressive therapy (including prednisone>15 mg/day for 1 month), silicosis, low body weight, gastrectomy, gastric bypass, jejunoileal bypass, HIV infection, injection drug use?		

Student Signature _____ Date _____

If you answered Yes to any of the above questions, you must have a TB Skin Test or IGRA Blood Test. *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 _____
Result _____ mm of Induration Negative ☐ Positive ☐
Note: If positive, chest x-ray must be completed

IGRA: Date Obtained _____ Method: QFT-GIT ☐ T-Spot ☐ Other _____

History of BCG vaccination? Yes ☐ No ☐ Note: If positive, IGRA must be completed.

Chest X-ray Date _____ Result _____ Please *attach copy of physician's report.*

Healthcare Provider Signature _____ Date _____