WOFFORD COLLEGE

INSTRUCTIONS

University: **Wofford College**

Student: DOB:

HOW TO COMPLETE THESE FORM(S):

- ☐ A licensed healthcare professional **MUST** complete and sign **THESE** forms. **ALL green sections are required.**
- ☐ **PRINT CLEARLY WITH DARK BLACK INK.** A computer will be reading your forms. Fill in circles completely.
- ☐ **NO** other forms of documentation will be accepted. (Blue Cards, Yellow Cards, State Immunization Records, etc. are NOT accepted)
- ☐ Do not fold, cut, or mark on the border lines of these forms.
- ☐ Include the Border Lines in your scanned images.
- ☐ Review your forms for completeness and accuracy. Double check **ALL** signatures. **MM/DD/YY date formats.**
- ☐ Consult your Healthcare Professional before receiving any of the following immunizations.

Your records are due by: 8/1/2017

REQUIRED

Required by regulation and /or policy to attend this university.

Documents:

Immunization Certificate

Immunization Dates:

Meningococcal (1 dose within 5 yrs)
Polio (4 doses or Pos. titer)
Hepatitis B (3 doses OR Pos. Quant. Titer)
MMR (2 doses OR Pos. Titer)
Tetanus (3 doses, 1 within 10yrs)

RECOMMENDED

Recommended for your general well being but NOT required.

Immunization Dates:

Varicella
HPV
Influenza
Tb Test Results
Meningococcal B

OPTIONAL

Optional information

Immunization Dates:

Hepatitis A
Pneumococcal
JE - Japanese Encephalitis
Typhoid
Yellow Fever
Rabies

UPLOADING YOUR FORMS:

- ☐ Review your forms for completeness and accuracy. **Double check ALL signatures.**
- ☐ Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- ☐ Upload your completed forms to your account at medproctor.com.
- ☐ You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- ☐ Check your University Email account regularly for messages from MedProctor regarding incomplete information.

You will be notified via email once your information is successfully verified.

BE AWARE:

* Incomplete/Illegible writing and poor images will be rejected.
* Completion of these forms by your due date will help expedite your registration process.

Do not upload this page.

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WOFFORD COLLEGE IMMUNIZATION CERTIFICATE

PRINT CLEARLY WITH DARK BLACK INK.
This form will be read by a computer.
Upload to medproctor.com

University: **Wofford College**

Student: DOB:

Green = Required
Blue = Recommended
Black = Optional

MMR Measles, Mumps, Rubella — Required
1st M M D D Y Y
2nd M M D D Y Y

MENINGOCOCCAL — Required
1st M M D D Y Y
2nd M M D D Y Y

MENINGOCOCCAL B — Recommended
1st M M D D Y Y
2nd M M D D Y Y

PNEUMOCOCCAL — Optional
One M M D D Y Y
PPSV23 ◯ PCV13 ◯

HEPATITIS B — Required
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

HPV - Human Papillomavirus — Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

Tetanus - last 3 with booster — Required
1st M M D D Y Y
2nd M M D D Y Y
Booster TDaP or TD M M D D Y Y

VARICELLA - Chicken Pox — Recommended
1st M M D D Y Y
2nd M M D D Y Y

HEPATITIS A — Optional
1st M M D D Y Y
2nd M M D D Y Y

POLIO - Inactivated — Required
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y
4th M M D D Y Y

INFLUENZA — Recommended
1st M M D D Y Y

Typhoid - Inactivated — Optional
One M M D D Y Y

Yellow Fever — Optional
One M M D D Y Y

RABIES - Pre-Exposure — Optional
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

REQUIRED - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

RECOMMENDED - Tuberculosis Test Results

Tb Skin PPD
Placed: M M D D Y Y
Read: M M D D Y Y
actual induration in MM only m m

mm and range REQUIRED (fill bubble)
◯ 0 mm
◯ 0 to < 5 mm
◯ 5 to < 10 mm
◯ 10 to < 15 mm
◯ 15 mm or larger

OR

Tb Blood T-Spot QuantiFERON
Test M M D D Y Y
Results ◯ Positive ◯ Negative

Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

OFFICE STAMP

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