HORRY GEORGETOWN TECHNICAL COLLEGE

Health Tracker Clinical Requirements

for

Dental Hygiene

Expanded Duty Dental Assisting

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Dental Hygiene and Expanded Duty Dental Assisting Clinical Requirements Checklist

- [ ] Criminal Background Check – Complete during assigned times. *See CBC/UDS/HT Instructional Packet.*
- [ ] Urine Drug Screening – Complete during assigned times. *See CBC/UDS/HT Instructional Packet.*

Your background check and drug screening results are automatically sent to our office.

- [ ] Castle Branch Compliance Tracker

The below documents are to be uploaded to your CB tracker.

- [ ] BLS (Basic Life Support) CPR Certification through AHA or ARC ONLY
- [ ] Health Physical completed on HGTC 6-page form
- [ ] 2 Step PPD (2 TB Skin Tests) or QFT Gold Blood Assay
- [ ] Seasonal Flu Vaccine (not required for summer semester)
- [ ] Tdap Vaccine within the past 10 years
- [ ] Hepatitis B 3- or 2- dose series or + Titer or Declination Waiver
- [ ] MMR 2 doses **or** + Titer Lab Results showing your scores with the reference ranges
- [ ] Varicella 2 doses **or** + Titer Lab Results showing your score with the reference range

IMPORTANT NOTES

- Any requirement that will expire mid semester must be completed before the semester begins. Example, your GHO Care Learning Modules expires in March or your QFT TB test expires in April, you must renew these before spring semester.
- **CPR Certification** – there are many different types of CPR Certification. **BLS (Basic Life Support) for HealthCare Providers through AHA or ARC ONLY is the certification that is required.**
- One year from the date of your physical, a **physical waiver** may be submitted annually ONLY if there has been no change in your health status.
- **2 Step PPD or QFT Gold Blood Assay**
  - A 2 Step PPD is two (2) Tuberculin skin tests. You will visit the physicians/clinics office four (4) times. You have step one administered and then read 48-72 hours later. Seven (7) days later after step one is read, you then have step two administered. Step two is then read 48-72 hours later. There is a max timeframe of 21 days (3 weeks) between Step 1 and Step 2.
  - You may have a QFT Gold Blood Assay in lieu of the traditional skin tests (2 Step PPD). This is a blood draw to test for tuberculosis.
  - After the initial 2 Step PPD or QFT, you will be required to receive a 1 step PPD or QFT Gold Blood Assay yearly. Do not let time lapse or you will need to complete the 2 Step PPD again. Example: If your 2 Step PPD was completed May 1, your annual 1 Step PPD MUST be completed no later than May 1 the following year.
- **If your PPD is positive or indeterminate (abnormal)**, you must have a chest x-ray immediately following the result. A chest x-ray is then required every 2 years.
- **If your PPD is positive or indeterminate (abnormal)**, a PPD symptom assessment form must be completed yearly.
- **The Seasonal Flu vaccine** is not required for the Summer Semester. It is required for Fall and Spring semesters.
- **Hepatitis B** - There are 4 options to choose from.
  Option 1 – Proof of Hepatitis B Immunizations: Provide a copy of your immunization record showing you received the Hepatitis B series. This can be from a childhood, school or military immunization record.
  Option 2 – Reactive Hepatitis B Surface Antibody Titer: Provide a copy of the Hepatitis B surface antibody titer lab results showing you are immune to Hepatitis B. If your titer is NON-REACTIVE, you must receive a booster with proof of a prior immunization record OR go to Option 4 and complete the declination. If an immunization record is not available, you must receive the series OR go to Option 4 and complete the Declination.
  Option 3 – Series in Progress - Start the 3-dose series, with the 1st dose now, 2nd dose in one month, 3rd dose should be five months after the 2nd dose. There is also a 2-dose series available which is 4 weeks apart (Dynavax /Heplisav-B).
  Option 4 – Declination Waiver - You may opt out. Please see the Hepatitis Declination Waiver on page 15.
- **MMR and Varicella** - There are 2 options to choose from.
  Option 1 – Proof of MMR and Varicella Immunizations: Provide a copy of your immunization or medical record showing you received 2 MMR and 2 varicella doses. This can be from childhood, school or military records.
  Option 2 – MMR and/or Varicella IgG Titer: Measles, mumps, rubella and varicella titers are only recommended if there is no proof of the vaccination history, but the student is certain they received the vaccines in the past. Positive results mean you are immune. A copy of the lab results showing your scores with the reference ranges is required. An additional titer is NOT required.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____

CPR: BASIC LIFE SUPPORT FOR HEALTHCARE PROVIDERS FORM

CPR REQUIREMENT:

- Basic Life Support Certification for the Healthcare Provider by American Heart Association (AHA) or American Red Cross (ARC) only
- Must renew CPR certification every 2 years

CPR Completion Date:	Certifying Agency:	Instructor's Initials:	
	☐ AHA ☐ ARC		

Certification:

☐ Yes, this student completed the **BLS CPR Certification for Healthcare Providers** through AHA or ARC.

_____

Instructor Printed Name Instructor Signature Date

CPR Instructor Affiliation _____

NOTE: If you are not receiving your CPR card/certificate the day of your class, please take this HGTC CPR BLS form with you so your instructor can complete it on your behalf. This form is valid for 30 days. You will need to remit a copy of your BLS CPR card/certificate within 30 days after your class.

To retrieve your card online from the American Heart Association, go here - https://ecards.heart.org/student/myecards

To retrieve your card online from the American Red Cross, go here - https://www.redcross.org/take-a-class/digital-certificate

Some area CPR/BLS Vendors – Others are also available

Prices and Information Subject to Change

Class Must Be:
BLS (Basic Life Support) Certification for Healthcare Provide
from the American Heart Association or the American Red Cross ONLY

Horry-Georgetown Technical College – Workforce Development – Courtney Sterbenz, Program Manager Cost: $165.00 (Materials Included) 950 Crabtree Lane, Building 600, Rm 631 Myrtle Beach, SC 29577 | courtney.sterbenz@hgtc.edu 843-477-2020 OR 843-477-2079 Dates of CPR classes can be found at www.hgtc.edu/jobtraining under Allied Health.	**Horry County Fire & Rescue** 2560 Main St Suite 1 Conway, SC 29526 | 843-915-5190 Melissa Rabon brownm@horrycountysc.gov Cost: Online Portion - $36.00 **www.onlineaha.org (Heart Code** BLS) In Person Skills – contact Melissa Rabon for price. **https://www.horrycountysc.gov/departments/fire-rescue/cpr-training/**
Bless Your Heart - CPR Cost: $45.00 (Materials Included) 843-457-3305 holly.wittschen@yahoo.com Holly Wittschen	**Andy Brown** Cost: $65 Myrtle Beach Area 843-957-0124 ambrownl2345@gmail.com
Midway Fire Department Battalion 82 Training Solutions, LLC Pawleys Island / Litchfield Area 843-545-3627 OR 843-267-2300 cgilmore@gtcounty.org OR mfdbc82@gmail.com http://www.midwayfirerescue.org	**Shannon & Greg Raxter** **Carolina Hartsavers** Cost: $85 (Materials Included) 843-333-8705 snraxter@gmail.com
Pee Dee Regional CTC Training Center ID: SC05608 1209 W Evans St Florence, SC 29501-3406 8436654671 carolinacenter@bellsouth.net http://PDCTC.COM	**Robeson Community College** 5160 Fayetteville Road Lumberton, NC 28360 Kenny Locklear rccems@robeson.edu 910-272-3407
Pee Dee Regional EMS 1314 W Darlington St Florence, SC 29501-2122 | 8436625771 Kim Dorsett – kim@pdrems.com www.pdrems.com http://www.pdrems.com	**Grand Strand Regional Medical Center** Class conducted at Coastal Grand Mall 2000 Coastal Grand Cir Suite 520 Myrtle Beach, SC 29577 843-839-9933 Dalena.nguyen2@hcahealthcare.com

All students must be Basic Life Support (BLS) CPR Certified through the American Heart Association (AHA) or American Red Cross (ARC). Certification is offered in two (2) formats, **Blended Learning** and an all **In Person Classroom Training**. For the blending learning, the first portion is completed online. Then the second portion, the hands-on skills assessment, MUST be completed in person. If you select one of the vendors above, their class may be the all **In Person Classroom Training**. Therefore, check with the instructor FIRST before purchasing the online portion.

NOTE: If you are not receiving your CPR card/certificate the day of your class, please take the HGTC CPR/BLS Form with you so your instructor can complete it on your behalf. The form is valid for 30 days. You will need to remit a copy of your BLS CPR card/certificate within 30 days after your class.

Student Health Record for Expanded Duty Dental Assisting and Dental Hygiene

Student Name: _____

Student H#_____

Please print in ink or type Section I before going to your physician for examination. Be sure to answer all questions fully and include your name at the top of each page. Health information, including immunization records will be released to authorized clinical agencies with your consent (as designated by your signature on page 2). Students will not receive clearance for clinical without a complete record. Students must submit the completed "Student Health Record" prior to program matriculation. If you have questions concerning a disability, or if requesting reasonable accommodations contact Student Counseling Services at 349-5302. If requesting accommodations, you must provide appropriate medical, psychological and/or psychiatric documentation to support this request.

SECTION I (to be completed by student)

Name: _____
(Last) (First) (Middle)

Other Name(s) Student Known As: _____ Birthdate: _____

Home Address: _____
(Street) (City) (State) (Zip)

Telephone: _____
(Home) (Cell) (Work)

Past Medical History: **ALLERGIES:**_____

Have you had?	Yes	No	**Have you had?**	Yes	No
Rubeola			Stomach/Intestinal Abnormality		
Rubella			Arthritis		
Mumps			Asthma		
Chicken pox (MD documented)			Hay fever		
Infectious Mono			Color blindness		
Positive TB Skin Test			Recurrent headaches		
Recurrent Herpes Viruses			Back problems		
Sexually Transmitted Disease			Organ transplant		
Heart disease			Insomnia		
Heart murmurs			Frequent Anxiety		
Mitral Valve Prolapsed			Frequent Depression		
High Blood Pressure			Worry or Nervousness		
Rheumatic fever			Hepatitis (specify: A,B,C,D,E)		
Diabetes			Epilepsy/Convulsions		
Kidney/Bladder Abnormality			Other (explain below):		

If you check any of these conditions, more information is required in the next section

HORRY GEORGETOWN TECHNICAL COLLEGE **Student Health Record for Expanded Duty Dental Assisting and Dental Hygiene**	Student Name: _____ Student H#_____ **Health Physical PAGE 2 of 6**

If you checked "Yes" to any medical history on the previous physical page, please give dates and treatments:

_____

_____

Please list any other medical conditions not addressed above:

_____

Please list all medications that you are currently taking:

_____

Student Signature _____ **Date** _____

SECTION II: Physical Examination (To be completed by the physician, physician assistant, or nurse practitioner)

Directions: Please review Section I completed by the student and then complete all of the following items in Section II.

Height: _____ Weight:_____ Blood pressure: _____ Pulse:_____ Respirations: _____ Temp:_____

Corrected Vision: RIGHT: 20/_____ Hearing: (Please circle)
LEFT: 20/_____ RIGHT: Normal Impaired LEFT: Normal Impaired

A. Does the student have any changes and/or concerns in the following systems? (Give dates, description of change, and treatment of ALL findings below)

System	**Yes**	**No**	System	**Yes**	**No**
Eyes			Musculoskeletal		
Ears			Metabolic/Endocrine		
Nose, throat			Genitourinary		
Neurological			Skin		
Respiratory			Immunological		
Cardiovascular (including murmurs)			Psychiatric		
Gastrointestinal			Other (please explain)		

B. If you have answered "yes" to any item in **A** above, please complete the following: (Additional information may be provided on a separate page identified with student's name).

Date	Diagnosis	Treatment	Restrictions/Limitations (Bending, lifting, pulling, etc.)

HORRY GEORGETOWN TECHNICAL COLLEGE **Student Health Record for Expanded Duty Dental Assisting and Dental Hygiene**	Student Name: _____ Student H#_____ **Health Physical PAGE 3 of 6**

ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS FOR ADMISSION AND PROGRESSION IN THE

_____
(PROGRAM NAME)

TECHNICAL STANDARDS OF THE DENTAL SCIENCES DEPARTMENT

The Dental Sciences Department is comprised of the Dental Hygiene and Expanded Duty Dental Assisting programs that require specific technical standards. These standards refer to all non-academic admissions criteria essential to participate in the program. In order to be considered, admitted, or retained in the program after admission, all applicants with or without accommodations must possess the following abilities:

ESSENTIAL FUNCTIONS REQUIRED OF STUDENTS

FOR ADMISSION AND PROGRESSION IN THE DENTAL SCIENCES DEPARTMENT

Applicants/students MUST be able to perform these essential functions. For those applicants requesting reasonable accommodations such as compensatory techniques and/or assistive devices, you MUST also be able to demonstrate the ability to become proficient in these essential functions.

If your ability to perform these essential functions depends on accommodations being provided, be advised that requests for accommodations must be presented to "Disability Services", and must be accompanied by appropriate medical, psychological and/or psychiatric documentation to support this request. You may contact "Disability Services" at (843) 349-5249.

HORRY GEORGETOWN TECHNICAL COLLEGE

Student Health Record for Expanded Duty Dental Assisting and Dental Hygiene

Student Name: _____

Student H#_____

ESSENTIAL FUNCTION	TECHNICAL STANDARD	SOME EXAMPLES OF NECESSARY ACTIVITIES
Physical Requirements	Must have use of both hands and dexterity in the fingers; body build must fit into dental operator's stool; use of feet.	Proper manipulation of dental instruments, materials, and dental handpieces; proper manipulation of foot pedals to activate handpieces and other dental equipment.
Data Conception	Must have the ability to gather, classify, and interpret information regarding patients or things, must be able to carry out appropriate actions in relation to the data received.	Proper interpretation of data given in the medical history and coordination of patient treatment with regards to the data.
Color Discrimination	Must be able to differentiate various shades of colors in a limited environment and space in the oral cavity.	Recognition of changes in the oral cavity from normal to abnormal with regards to tissue color.
Manual Dexterity/Motor Coordination	Must have excellent eye-hand coordination and manual dexterity.	Manipulating dental instruments in a small area to discern changes in surface texture without causing tissue trauma, controlling pressure exerted by dental handpieces on dental tissue, dexterity required for instrument exchange.
Physical Communication	Must be able to perceive sound.	Talking to patients on the telephone, hearing commands through operator's face mask, discerning blood pressure sounds through a stethoscope.
Reasoning Development	Must be able to apply principles of logical or scientific thinking to define problems, collect data, establish facts, and draw valid conclusions.	Interpreting knowledge that has been learned in the classroom towards patient treatment.
Visual Acuity	Must be able to see minute, detailed shapes from a 2-foot distance.	Identification of working ends of dental instruments and other dental implements.
Language Development	Must be able to read and comprehend complex information; able to communicate the same type of information through speech and in writing.	Communication to patients of technical information in a clear concise manner at an understandable level.
Numerical Ability	Must be able to determine percentages, convert fractions, ratio, and proportions as well as basic mathematical skills.	Calculation of percentages with regards to plaque indices, counting of teeth, calculation of fees and percentages of those fees.

HORRY GEORGETOWN TECHNICAL COLLEGE

Student Health Record for Expanded Duty Dental Assisting and Dental Hygiene

Student Name: _____

Student H#_____

Program: _____

Form/Spatial Ability	Must be able to view in 3-dimensional relationships, distinguish subtle changes from one form or shape to another, discriminate intricate measurements.	Visualize tooth morphology during cavity preparation, documentation of probe readings during oral examination and periodontal charting.
Personal Temperament	Must be able to maintain a professional attitude and appearance, deal with stress, adapt to change, and function and focus in an environment with multiple extraneous stimuli.	Progress through a rigorous, challenging curriculum that is stressful, while maintaining a professional attitude and appearance when treating patients in an open-bay clinic or dental office setting that will have some noise and interruption.

NOTE: Students with documented disabilities through "Disability Services" of HGTC should inform their Course Professor at the beginning of each course to allow for accommodations for testing, note taking, etc.

Does the student have any restrictions/limitations?	Yes	_____	No	_____
If yes, how many weeks are restrictions/limitations in effect:				
If yes, what date will the restrictions/limitations be lifted:				
If yes, will the student be required to follow-up with your office:	Yes	_____	No	_____
If yes, date of scheduled appointment for follow-up:				

I hereby certify to the best of my knowledge that the preceding information is complete and accurate.

_____ _____

Print Name of Physician, Physician Assistant, or Nurse Practitioner Date

_____ _____

Signature of Physician, Physician Assistant, or Nurse Practitioner Date

NOTE: Some allied health programs may have additional requirements. Individual students assume responsibility for ensuring all requirements have been met according to the designated curriculum for the program of which he/she is seeking entry.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____ **Health Physical PAGE 6 of 6**

WAIVER OF REPEAT PHYSICAL EXAMINATION / NOTIFICATION OF CHANGE IN HEALTH STATUS

Your initial Health Science Division – Student Health Physical Record is valid for one year. If you have had no changes in your medical history, you are eligible to complete this Waiver/Notification Form. If you have had any changes in your medical status, you are required to complete a new Health Science Division – Student Health Physical Record.

I, _____, as a student enrolled in a Nursing or Health Science Program at Horry-Georgetown Technical College, do hereby declare that I have sustained no changes in my physical health condition from my most recent student health examination required for the program.

- It is my understanding that in the event a physical health change occurs, it is my responsibility to immediately notify the following individuals of such change(s):
    1. Primary Course instructor and Clinical Instructor
    2. Clinical Admissions Office
- Following notification of health physical change(s), it is my responsibility to:
    1. Make an appointment with a healthcare provider for physical examination and completion of a new Health Science Division – Student Health Physical Record.
    2. Provide the completed Student Health Physical Record to the Clinical Admissions Office for verification of current eligibility for clinical without restrictions (specifically page 5 of 6 of the health physical).
    3. Contact Student Affairs at (843) 349-5249 if you would like to request accommodations.
- If restrictions are indicated on the Student Health Physical Record, the Clinical Admissions Office will notify the student's designated Program Department Chair and/or Dean for guidance regarding further clinical continuation.
- In the event I fail to notify the appropriate individuals of such health changes, Horry-Georgetown Technical College is released from all liability relevant to my physical health status, and such failed actions on my behalf may result in dismissal from the program of study and/or constitute legal action thereof.

Student Printed Name Student Signature Date

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

Tuberculosis Screening

HGTC students are initially required to complete a 2-Step PPD, which consists of two tuberculin skin tests (4 office visits) **OR** a QuantiFERON (QFT) Gold Blood Assay, which is a blood draw to test for Tuberculosis. A 1-Step PPD or QFT Gold Blood Assay is required yearly after the initial process if completed within the same one year.

If you elect to have the QuantiFERON (QFT) Gold Blood Assay, submit a copy of the lab results.

If you elect to have the tuberculin skin test(s), the below section is **TO BE FULLY COMPLETED BY A HEALTHCARE PROVIDER:**

1st Step – Visit 1:

Date Administered: _____ Time: _____

Site: (please circle) Left FA Right FA Lot#:_____ Expiration Date:_____

Healthcare Provider Signature test was administered: _____

Your PPD must be read within 48-72 hours.

1st Step – Visit 2: ***Results:*** (please circle) Negative Positive

Date Read:_____ Time Read:_____ Induration:_____mm

Healthcare Provider Signature test was read: _____

Step 2 should be administered 7-21 days after Step 1 was administered.

There is a max time frame of 21 days between Step 1 and Step 2

2nd Step - Visit 3:

Date Administered: _____ Time: _____

Site: (please circle) Left FA Right FA Lot#:_____ Expiration Date:_____

Healthcare Provider Signature test was administered: _____

Your PPD must be read within 48-72 hours.

2nd Step – Visit 4: ***Results:*** (please circle) Negative Positive

Date Read:_____ Time Read:_____ Induration:_____mm

Healthcare Provider Signature test was read: _____

- If the QFT or PPD result is **positive** or **indeterminate (abnormal)**, a student must have a medical assessment, provide TB results, proof of negative CXR and complete the symptom assessment form.
- Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

INFLUENZA FORM

The seasonal flu vaccine is required for the Fall and Spring semesters. It is not required for the Summer semester. It typically is available every August and will be due in September.

Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials

Certification:

Signature below indicates verification of above initials in administration of, or reporting of, documented result for Influenza Immunization(s).

_____

Healthcare Provider Signature Title Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

Tetanus, Diphtheria, Pertussis (TDAP) Form

This form must be complete or an immunization/medical record is needed

Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Initials

Certification:

Signature below indicates verification of above initials in administration of TDAP immunization and/or titer result.

_____

Healthcare Provider Signature Title Date

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

HORRY GEORGETOWN TECHNICAL COLLEGE

Health Science Division – Student Health Record

Student Name: _____

Student H#_____

Program: _____

HEPATITIS B FORM

Option 1 – Proof of prior Hepatitis B Immunization: Provide a copy of your immunization record showing you received the Hepatitis B series. This can be from a childhood, high school or military immunization record.

Option 2 – Reactive Hepatitis B Surface Antibody Titer: Provide a copy of the Hepatitis B surface antibody titer lab results showing you are immune to Hepatitis B. If your titer is NON-REACTIVE, you must receive a booster with proof of a prior immunization record. If an immunization record is not available, you must receive the series OR go to Option 4 and complete the Declination.

Option 3 – Series in Progress: If you elect to receive the series, please circle which series:
3-dose series or **2-dose series** or **1 booster** (will include prior immunization record with this form)
You MUST also check the Series in Progress box below and sign with your signature and date.
This form must be complete or an immunization record is required. "Historical" with the dates will not be accepted.

Injection	Lot #	Manufacturer:	Expiration:	Injection Site:	Date	Healthcare Provider Signature
1.						
2.						
3.						

☐ I am in the process of receiving the Hepatitis B Vaccine and will provide documentation of all vaccinations as they are completed. Until I am fully vaccinated, I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection.

_____

Student Signature **H#** **Date**

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

Option 4 – Declination Waiver:

☐ I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been informed of the opportunity to be vaccinated with Hepatitis B Vaccine. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B. If in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I will decide at that time.

_____

Student Signature **H#** **Date**

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#_____ Program: _____

MEASLES, MUMPS, RUBELLA (MMR) and VARICELLA (CHICKENPOX) FORM

Option 1 – Proof of MMR and Varicella Immunizations: Provide a copy of your immunization or medical record showing you received 2 MMR and 2 varicella doses. This can be from childhood, school or military records.

OR

Option 2 – MMR and/or Varicella IgG Titer: Measles, mumps, rubella and varicella titers are only recommended if there is no proof of the vaccination history, but the student is certain they received the vaccines in the past. Positive results mean you are immune. A copy of the lab results showing your scores with the reference ranges is required. An additional titer is NOT required.

To be completed by a healthcare provider ONLY if titer lab results show non-immunity AND you do not have your immunization record or if you are missing a dose. Please do NOT record historical vaccinations here.

Injection	Lot #	Manufacturer:	Exp Date:	Injection Site:	Date	Healthcare Provider Signature
MMR #1						
MMR #2 (without prior immunization record						

Injection	Lot #	Manufacturer:	Exp Date:	Injection Site:	Date	Healthcare Provider Signature
Varicella #1						
Varicella #2 (without prior immunization record						

Documentation may be provided on other forms or records but must meet the stated guidelines for clinical clearance.

How do I obtain a copy of my immunization record?

If you received your vaccinations in the state of South Carolina, you may be able to retrieve a copy of your immunization record from the SIMON portal by going to simonportal.dh.sc.gov. For other states, there may be similar websites. You may also try contacting the health department from the county you received your vaccinations for guidance. Your high school may have a copy as well.

Immunization Cost Estimates for Students
WITHOUT Health Insurance Coverage
Some of these ARE covered under most health insurance plans

DISCLAIMER: This information is to be used as a guide only, as it is subject to change. HGTC cannot be held responsible for the prices listed below. It is the student's responsibility to call and confirm availability, pricing, and insurance requirements. HGTC is not affiliated with any of these providers regarding provision of healthcare services and is unable to recommend any specific provider.

You do not have to use these providers. YOU MAY USE YOUR OWN PROVIDER.

The prices below updated June 2025. They are subject to change. Call ahead for pricing.

Immunization	Care Now 843-626-2273 (7 Locations)	CVS Minute Clinic 866-389-2727	Doctor's Care 843-238-1461	South Strand Internist and Urgent Care 843-945-3030	**McLeod Health Carolina Forest 843-646-8400	BraVa Med Spa 843-750-0324	Southern Urgent Care 843-357-4357
Office Visit Fee	$180.00	NA	$199.00	$95 - $171	NA	$100.00	$0.00
Physical – Included in Office Fee	180.00	$75.00 - $100.00	$115.00	$80.00	$50.00	Included in Office Visit	$45.00
Tuberculin Skin Testing (PPD) x 1 OR *QFT Gold Blood Assay	$20.00 (PPD) $120.00 (QFT)	$74.00 - $139.00 (PPD)	$35.00 $65.00 (QFT)	$19.00 $112.00 (QFT)	$10.00 (1 PPD) $52.00 (QFT)	$30.00 (PPD) $125 (QFT)	$35.00 (PPD) $110.00 (QFT)
Chest X-Ray with Positive PPD	$45.00	NA	$110.00	$50 - $200	$75.00	NA	$135.00
MMR IgG Titer	$80.00	$142 - $169	$80.00	NA	$14.75 for MMRV	$60.00	$50.00
Varicella IgG Titer	$75.00	$142 - $169	$80.00	NA		$30.00	$50.00
Hep B Surface Titer	$70.00	$142 - $169	$60.00	NA	$6.50	$40.00	$30.00
MMR Vaccine x 1	$130.00	$143.00	NA	$100.00	$105.00	NA	NA
Hep B Vaccine 2 Dose / 3 Dose	2 Dose -$180.00 ea Admin Fee - $52.00	$99 - $139 ea	2 Dose $175 ea	2 Dose $58 ea 3 Dose $23 ea	2 Dose - $122.50 ea 3 Dose - $60.00 ea	NA	NA
Varicella Vaccine x1	$220 if avail	$150 - $275 ea	$80.00	$172.00	$200.00	NA	NA
TDAP (Adacel) Vaccine	$80.00	$103.00	$71.00	$45.00	$58.00	NA	$101.00
Flu	$20.00	$75.00 - $110.00	$40.00	$19.00	$25.00	NA	NA

****If visiting McLeod Health (listed above), you must make an appointment & inform them you are an HGTC student to receive these prices. Be sure to show them your student ID at your appt.****

These offices offer pricing on a sliding scale, by you may need to make an appointment far in advance:

- Little River Medical Center, Little River, SC 843-663-8000
- Careteam +, Conway, SC, www.careteamplus.org, 843-234-0005

For students who meet certain income guidelines, some services are provided at low or no cost through the **SC Health Departments**. Call (855) 472-3432 to make an appointment at any of these locations.

- Myrtle Beach Health Dept, 21st Ave, Myrtle Beach (843) 448-8407
- Conway Health Dept., Industrial Park Road, Conway (843) 915-8800
- Stephen's Crossroad Health Dept., Hwy 57 North, Little River (843) 915-5654
- Georgetown County Public Health Department, Lafayette Cir, Georgetown (843) 546-5593

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#: _____

SYMPTOM ASSESSMENT FORM

(Required Yearly)

Instructions:

*Complete this form **ONLY** if you had a Positive (+) Tuberculin Skin Test with a Negative (-) CXR.*

Date: _____ Date of Positive PPD: _____ Date of Negative CXR: _____

Have you been treated with tuberculosis medication? ❑ Yes ❑ No

Have you ever received a BCG (tuberculosis vaccine)? ❑ Yes ❑ No

Have you been exposed to an isolated case of TB this year? ❑ Yes ❑ No

Do you have any of the following?

- Productive cough (≥ 3 weeks) ❑ Yes ❑ No
- Persistent weight loss without dieting ❑ Yes ❑ No
- Persistent low-grade fever ❑ Yes ❑ No
- Night sweats ❑ Yes ❑ No
- Loss of appetite ❑ Yes ❑ No
- Swollen glands in the neck ❑ Yes ❑ No
- Recurrent kidney or bladder infections ❑ Yes ❑ No
- Coughing up blood ❑ Yes ❑ No
- Shortness of breath ❑ Yes ❑ No
- Chest pain ❑ Yes ❑ No

If you answered "YES" to any of the above questions, please explain:

_____

_____

_____

(Note: Clearance from a primary care provider, which may include repeat CXR, is required prior to clinical attendance if you answered "YES" to any of the above questions).

Student's Signature: _____ Date: _____

HORRY GEORGETOWN TECHNICAL COLLEGE **Health Science Division – Student Health Record**	Student Name: _____ Student H#: _____

VACCINE ALLERGY/WAIVER FORM

Vaccine	Contraindication to student receiving vaccine:	Initials
❑ Influenza ❑ TDAP ❑ Hepatitis B ❑ MMR ❑ Varicella	❑ Documented Allergy to Vaccine or Component of Vaccine *Additional information required below* ❑ **Pregnancy** EDC: _____ • Must be for live virus vaccine • Date vaccine can safely be administered _____ ❑ Currently Immunosuppressed/Immunocompromised • Disease/Condition: _____ • Date vaccine can safely be administered _____	

If requesting a Medical Exemption, please have your physician complete and sign below.

[ ] Anaphylaxis [ ] Guillain-Barré Syndrome [ ] Other Severe Reaction or medical condition:
Please specify reaction/condition: _____

_____

_____

_____

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Certification:
Signature below indicates **verification of above initials** in reporting of valid contraindication for student not receiving designated vaccine.

_____

Provider Name | Provider Address | Provider Phone Number

_____

Signature | Must be signed by a MD or DO | Date

_____