

Checklist for Students and Parents

(This page is for you to keep.)

Health History Records Due Date: July 4, 2008 (February 1, 2009 for Spring Admissions)

MAIL THE COMPLETED FORM IN ITS ENTIRETY to:

******R-MC STUDENT HEALTH CENTER PO BOX 5005 Ashland, VA 23005******

Faxes will not be accepted.

Students not in compliance with ALL of the TB screening and immunization requirements for entrance to Randolph-Macon College will have class registration and residence hall access blocked as of August 1.

Do not use pencil to complete the Health History Record.

Tuberculosis screening questionnaire required for ALL students to determine need for TB skin test.

Required Immunizations for ALL (including commuters) students:

- MMR: Measles, mumps, rubella-2 doses of each
- Tetanus booster (within 10 years)
- Polio Series
- Hepatitis B: Completed 3 shot series or signed waiver
- Meningococcal meningitis: Vaccine or signed waiver

Recommended Immunizations:

- Varicella (Chicken Pox)
- Hepatitis A

Pre-college health examinations:

Have a comprehensive physical examination and necessary dental and eye examinations before coming to R-MC.

Health Insurance:

Have appropriate medical insurance and understand your coverage. This includes a policy providing adequate coverage while living in Richmond, VA for services such as emergency care, lab tests and x-rays. Carry your health insurance card and prescription drug card with you.

Medical records and prescriptions:

Have a record of your prescriptions, including medication strength, dosage and diagnosis/reason for treatment. If you have chronic/serious medical problems, have a medical summary sent to the Student Health Center by your treating physician. Make arrangements with a local pharmacy for prescription service. Understand your prescription drug insurance coverage.

Allergy shots: The Student Health Center administers allergy shots. A physician's detailed orders are required. If initiating allergy shot therapy, we require the ordering physician give the first injection.

Student Health Center: Please view our Web site for hours of operation and services offered.

<http://www.rmc.edu/offices/student-health>

First aid supplies:

Bring digital thermometer, acetaminophen, ibuprofen, cold medications, small container of band-aids, topical antibacterial cream, a chemical cold pack and sunscreen.

You will be notified if your form is incomplete.



**Randolph-Macon
College**
Ashland, Virginia

Student Health Center Phone (804)752-3041
Email Address: StudentHealth@rmc.edu
Web site: www.rmc.edu
PO Box 5005 Ashland VA 23005

FOR OFFICE USE ONLY: Complete
PPD PPD Ex Td Polio Hep B Hep B Waiver
MMRs OR Measles Mumps Rubella Men Vax
 Men Waiver Varicella Imm Varicella not imm
Missing: _____
Notified: _____
If transfer, year of grad _____

HEALTH HISTORY RECORD – 2008-2009
Deadline All Students (including Commuters) July 4, 2008
(Spring Semester Transfers – February 1, 2009)

(Please keep a copy for your records)

MAIL THE COMPLETED FORM IN ITS ENTIRETY TO THE STUDENT HEALTH CENTER.
FAXES WILL NOT BE ACCEPTED.

Name _____
Last First Middle

Male Female Date of Birth ____/____/____ Social Security _____
mo day year (SS# required for medical purposes)

Permanent Address: _____
Street City State /Country Zip Code

Country of Birth _____ Email _____

Phone _____ Cell _____ Expected Year of Graduation _____

MEDICAL HISTORY (Please check all that apply and explain any "Yes" answers below)

Yes No	Yes No	Yes No
<input type="checkbox"/> <input type="checkbox"/> Allergies (annual/seasonal)	<input type="checkbox"/> <input type="checkbox"/> Eating Disorders	<input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Emotional Problems/Depression/Anxiety	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Asthma/Exercise-Induced Asthma	<input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Problems	<input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted
<input type="checkbox"/> <input type="checkbox"/> Bone/Joint Disorder	<input type="checkbox"/> <input type="checkbox"/> Gynecological Problems	<input type="checkbox"/> <input type="checkbox"/> Elevated Cholesterol
<input type="checkbox"/> <input type="checkbox"/> Cancer	<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> <input type="checkbox"/> Chicken Pox	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Frequent Throat Infections
<input type="checkbox"/> <input type="checkbox"/> Circulatory Problems/Blood Clots	<input type="checkbox"/> <input type="checkbox"/> Hepatitis/Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Frequent Ear Infections
<input type="checkbox"/> <input type="checkbox"/> Convulsions/Seizures/Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Kidney/Urinary Problems	<input type="checkbox"/> <input type="checkbox"/> Other – Explain Below
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Mononucleosis	

Remarks or Additional Information: _____

Allergies: medication/foods, etc (include reaction) _____

Significant illness/hospitalization/surgery (include dates): _____

History of psychiatric/psychological condition (include dates): _____

Person to be notified in case of emergency: Name: _____

Address: _____ Phone Number: _____

Health Insurance Information: (please include a copy of your card-front and back)

Insurance Company _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Name of Policy Holder _____ Individual ID _____ ID/Group # _____

THIS PAGE MUST BE COMPLETED BY HEALTH CARE PROVIDER

(All information must be in English)

Student's Full Name: _____ Social Security # _____

REQUIRED TUBERCULOSIS (TB) SCREENING

NON-US BORN STUDENTS: If you were born in a country *NOT* listed below, you will have TB screening at the Student Health Center upon arrival to campus. Students will be contacted via email with the date of the mandatory TB screening before classes begin at R-MC.

American Region: Antigua and Barbuda, Barbados, Canada, Dominica, Grenada, Jamaica, Netherlands Antilles, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, St. Vincent & Grenadines, United States, Virgin Islands (US and British)

European Region: Andorra, Austria, Belgium, Czech Republic, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Israel, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom

Asian Region: no exceptions in this region

Western Region: American Samoa, Australia, Cook Islands, New Zealand

Non-US Born students not meeting the above criteria, proceed to "All Other Students" below.

ALL OTHER STUDENTS: This TB screening must be completed by a healthcare professional **AFTER MARCH 1** of this year.

1. Does the student have signs or symptoms of active tuberculosis (TB) disease?

No If **No**, proceed to question 2.

Yes If **Yes**, proceed with appropriate evaluation to exclude active TB, including tuberculin skin testing (PPD), chest x-ray, and sputum evaluation, as indicated.

2. Use the following criteria to determine if the student is a member of a high risk group:

- ◆ Unexplained weight loss, night sweats, persistent cough > 3 weeks ◆ Immunosuppressive therapy
- ◆ Cough with the production of bloody sputum ◆ Healthcare worker or student entering a healthcare profession
- ◆ Close contact with a known case of active TB ◆ Employee or long-term volunteer of a nursing home, homeless
- ◆ Cancer, diabetes, kidney disease shelter or correctional facility
- ◆ Use of illegal injected drugs ◆ Removal of part of your stomach
- ◆ HIV infection ◆ Silicosis
- ◆ Lived or traveled greater than 1 month in any country **EXCEPT** the following:

American Region: Antigua and Barbuda, Barbados, Canada, Dominica, Grenada, Jamaica, Netherlands Antilles, Puerto Rico, Saint Kitts and Nevis, Saint Lucia, St. Vincent & Grenadines, United States, Virgin Islands (US and British)

European Region: Andorra, Austria, Belgium, Czech Republic, Cyprus, Denmark, Finland, France, Germany, Greece, Iceland, Israel, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom

Asian Region: no exceptions in this region

Western Region: American Samoa, Australia, Cook Islands, New Zealand

(Based on data from 2004 World Health Organization Global TB Control Report.)

3. Using criteria in question 2 above, is student a member of a high risk group?

NO **IF NO, STOP. NO TUBERCULIN SKIN TEST IS REQUIRED.**

YES If **Yes**, place tuberculin skin test (PPDs placed **BEFORE MARCH 1 WILL NOT BE ACCEPTED.**)

Mantoux test acceptable only: 0.1 ml of PPD tuberculin containing 5 tuberculin units, intradermally, inner forearm.

A history of BCG vaccination should not preclude testing.

Date PPD placed: _____ Date PPD read: _____ Results in millimeters: _____

(Record actual mm of induration, transverse diameter; if no induration, record "0")

Interpretation (base on mm of induration, as well as risk factors): Positive _____ Negative _____

Chest x-ray (required if current PPD positive or prior history of positive PPD.) Chest x-ray is not an acceptable screening test in lieu of tuberculin skin test.

Date of Chest x-ray: _____ Result: Normal _____ Abnormal _____

If chest x-ray is indicated, please attach written report and supporting documentation of the positive PPD. Report must be in English.

All immunization dates must be verified by a health care provider or public health official with full name, signature, title and complete address and phone number. This form will be returned if the health care provider is a family member.

Signature of Health Care Provider: _____ Date: _____

Please print or stamp examiner's name: _____ Phone: _____

Address: _____ Fax: _____

PHYSICAL EXAMINATION RECORD

(This Form must be completed by health care provider)

Student's Full Name: _____ **Social Security #** _____

Required of NCAA athletes ONLY: (please have student athlete sign this box)

- 1. Sport: _____
- 2. Urine Screen: Urinalysis (dip) glucose _____ protein _____ blood _____
- 3. Blood Work: Hgb _____ Hct _____
- 4. Physical Exam: NCAA requirement to participate in your sport.

Please sign below to authorize the Health Center to provide a copy of your Health History Record to the Athletic Training Room.

Student Athlete's Signature _____
Date _____

Drug Allergies: _____

Physical Examination:

Vision: (Corrected) R 20/____ L 20/____ (Uncorrected) R 20/____ L 20/____

Height: _____ (inches) Weight: _____ (pounds) B/P: ____/____

Pulse: _____

Normal Abnormal

 1. HEENT

 2. Neck

 3. Lungs

 4. Heart

 5. Abdomen

Normal Abnormal

 6. Genitourinary

 7. Musculoskeletal

 8. Neurological

 9. Skin

Describe any abnormalities: _____

Medical/Psychological conditions: _____

Current Medications:

Name of Medication	Dosage	Indication

Dietary Requirements: _____

Recommendations for physical activity: Unrestricted Restricted
(Explain restrictions)

Other Pertinent Information: _____

This form will be returned if the health care provider is a family member.

Signature of Health Care Provider: _____ Date: _____

Please print or stamp examiner's name: _____ Phone: _____

Address: _____ Fax: _____