Check-list 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	
☐	☐	Allergies (annual/seasonal)	☐	☐	Eating Disorders	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Emotional Problems/Depression/Anxiety	☐	☐	Tuberculosis
☐	☐	Asthma/Exercise-Induced Asthma	☐	☐	Gastrointestinal Problems	☐	☐	Sexually Transmitted
☐	☐	Bone/Joint Disorder	☐	☐	Gynecological Problems	☐	☐	Elevated Cholesterol
☐	☐	Cancer	☐	☐	Frequent Headaches	☐	☐	High Blood Pressure
☐	☐	**Chicken Pox**	☐	☐	Heart Disease	☐	☐	Frequent Throat Infections
☐	☐	Circulatory Problems/Blood Clots	☐	☐	Hepatitis/Liver Disease	☐	☐	Frequent Ear Infections
☐	☐	Convulsions/Seizures/Epilepsy	☐	☐	Kidney/Urinary Problems	☐	☐	Other – Explain Below
☐	☐	Diabetes	☐	☐	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: _____

THIS PAGE MUST BE COMPLETED BY HEALTH CARE PROVIDER

(All information must be in English. See reverse side for guidelines to completing immunization requirements)

Student's Full Name:_____Social Security # _____

PLEASE NOTE: It is the student's responsibility to return the ORIGINAL, completed Health History Record by July 18, 2008 for Fall Semester or February 1, 2009 for Spring Semester. MAIL THE COMPLETED FORM *IN ITS ENTIRETY* TO THE STUDENT HEALTH CENTER. *Faxes will not be accepted.*

STUDENTS NOT IN COMPLIANCE WITH ALL OF THE TB SCREENING AND IMMUNIZATION REQUIREMENTS FOR ENTRANCE TO R-MC WILL HAVE CLASS REGISTRATION AND RESIDENCE HALL ACCESS BLOCKED.

REQUIRED IMMUNIZATIONS	DATES ADMINISTERED
Tetanus/Diphtheria Booster (required within past 10 years)	
☐ Td	___/___/___
OR ☐Tdap	M D Y
Polio	
Completed Primary Series? ☐ No ☐ Yes	Date last dose given ___/___/___ M D Y
Hepatitis B	
#1 ___/___/___ #2___/___/___ #3___/___/___ M D Y M D Y M D Y	**OR Waiver signed →** (Must sign waiver if series is not complete at time forms are submitted to R-MC.)
Alternatives 2-dose adolescent series Twinrix	
Measles, Mumps and Rubella (MMR) *(after first birthday and if born after 1971)*	
MMR #1 *after* first birthday ___/___/___ M D Y	
MMR #2 at least 30 days after MMR#1 ___/___/___ M D Y	

WAIVERS

Hepatitis B Waiver
(please check one of the boxes)

☐ I have read the information on the Web site about Hepatitis B and the Hepatitis B vaccine. I understand the risks of the disease, however, I choose not to receive the vaccine.

☐ I have not completed the series of 3 vaccines but understand I must sign the waiver to complete my records.

Student's Printed Name: _____

Date of Birth:_____

Signature:_____

Date:_____
(Parent/guardian's signature required if student is under the age of 18)

IF MEASLES, MUMPS AND RUBELLA GIVEN AS INDIVIDUAL ANTIGENS – DOCUMENT ALL VACCINATIONS GIVEN

Measles (Rubeola) two doses vaccine ***required*** #1 ___/___/___ #2___/___/___ (after first birthday and 1967) M D Y M D Y	**OR** Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)
Mumps two doses vaccine ***required*** #1 ___/___/___ #2___/___/___ (after first birthday and 1967) M D Y M D Y	**OR** Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)
Rubella two doses vaccine ***required*** #1 ___/___/___ #2___/___/___ (after first birthday and 1969) M D Y M D Y	**OR** Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)

Meningococcal Meningitis	
Menactra ☐ ___/___/___ *OR* Menomune☐ M D Y *(Menomune acceptable if after 7/1/06)*	**OR Waiver signed →** (Must sign waiver if not vaccinated at time forms are submitted to R-MC)
RECOMMENDED IMMUNIZATIONS	
Varicella (Chicken Pox) #1 ___/___/___ #2___/___/___ M D Y M D Y (Must be in English.)	**OR** Serological confirmation of immunity. Attach copy of lab results.
Hepatitis A #1 ___/___/___ #2___/___/___ M D Y M D Y	
Human Papilloma Virus #1 ___/___/___ #2___/___/___ #3___/___/___ M D Y M D Y M D Y	

Meningococcal Vaccine Waiver
(please check one of the boxes)

☐ I have read the information on the Web site about meningococcal meningitis and understand the risks of the disease; however, I choose not to receive the vaccine. I understand that in the event of an outbreak, unvaccinated students will be at increased risk for contracting the illness.

☐ The vaccine is not available or I have not yet been vaccinated, but understand I must sign the waiver to complete my records.

Student's Printed Name: _____

Date of Birth:_____

Signature:_____ Date:_____

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		Normal	Abnormal	
☐	☐	1. HEENT	☐	☐	6. Genitourinary
☐	☐	2. Neck	☐	☐	7. Musculoskeletal
☐	☐	3. Lungs	☐	☐	8. Neurological
☐	☐	4. Heart	☐	☐	9. Skin
☐	☐	5. Abdomen			

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: _____