Randolph-Macon College
Student Health Center
P.O. Box 5005
Ashland, VA 23005
Phone: 804.752.3041
Email: studenthealth@rmc.edu

Checklist for Students and Parents

(This page is for you to keep)

□ **Health History Records**

□ Please mail the 4 ORIGINAL Health History Record pages with ORIGINAL SIGNATURES to the Student Health Center**. DUE: August 1, 2012** (Fall Admission) **January 31, 2013** (Spring Admission) ***Faxes will NOT be accepted.***

□ Please sign your full name at the TOP of Pages 2, 3 and 4.

□ Do not use pencil to complete the Health History Form.

□ **Tuberculosis (TB) Risk Assessment (page 2) is required for ALL students**. Students not in compliance with *ALL* immunization requirements and TB screening for entrance to Randolph-Macon College ***will have class registration and residence hall access blocked.***

□ **Immunizations:**

REQUIRED for ALL students (including commuters):

- □ MMR (measles, mumps, rubella): 2 doses or equivalent individual doses of each
- □ Tetanus booster (within past 10 years)
- □ Polio Series
- □ Hepatitis B-- completed series or signed waiver declining vaccine
- □ Meningococcal Meningitis—or signed waiver declining vaccine

RECOMMENDED:

- □ Varicella (chickenpox) or history of disease
- □ Hepatitis A
- □ Human Papilloma Virus (HPV--series of 3 injections)

□ **Pre-college health examinations:** Have a **REQUIRED** comprehensive physical examination and recommended 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 when visiting the Health Center.

□ **Medical Records and Prescriptions:** Have a record of your prescriptions, including medication strength, dosage and diagnosis/reason for treatment. NOTE: **We must have documentation of any psychotropic drug prescription from the diagnosing provider and office notes regarding the diagnosis given.**

□ **Allergy Shots:** The R-MC Student Health Center administers allergy injections. A prescribing allergist's detailed orders are required. If initiating allergy shot therapy, *we require the first injection be given at the allergist's office.*

□ **First Aid Supplies:** Recommended items to bring with you to campus: digital thermometer, acetaminophen, ibuprofen, cold medications, Band-Aids, topical antibacterial cream, a chemical cold pack, and sunscreen.

□ **Student Health Center Web site: http://www.rmc.edu/offices/student-health.aspx**

Student Health Center
PO Box 5005 Ashland VA 23005
Phone: (804)752-3041
Email: studenthealth@rmc.edu
Web: http://www.rmc.edu/offices/student-health.aspx

For Office Use Only: Completed_____
Needed:_____
_____
_____
_____

HEALTH HISTORY RECORD – 2012-2013

- **Please mail the 4 ORIGINAL, COMPLETED, AND SIGNED Health History Record pages directly to the Student Health Center. DUE: AUGUST 1, 2012 (Fall Admission) January 31, 2013 (Spring Admission)**
- **Faxes will NOT be accepted**

Name:_____ Date of Birth: ____/___/____
Last *First* *Middle* *mo day year*

Permanent Address:_____
Street *City* *State /Country* *Zip Code*

Country of Birth: _____ Email: _____

Home Phone: _____ Cell Phone:_____

S.S. #_____ □ Male □ Female Expected **R-MC** Graduation Date:_____
(Required for medical purposes)

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	□	□	Gastrointestinal Problems	□	□	Tuberculosis
□	□	Asthma/Exercise-Induced Asthma	□	□	Gynecological Problems	□	□	Sexually Transmitted Diseases
□	□	Bone/Joint Disorder	□	□	Frequent Headaches	□	□	Elevated Cholesterol
□	□	Cancer	□	□	Heart Disease	□	□	High Blood Pressure
□	□	**Chicken Pox**	□	□	Hepatitis/Liver Disease	□	□	Frequent Throat Infections
□	□	Circulatory Problems/Blood Clots	□	□	Kidney/Urinary Problems	□	□	Frequent Ear Infections
□	□	Convulsions/Seizures/Epilepsy	□	□	Mental Health Disorder	□	□	ADD/ADHD
□	□	Diabetes	□	□	Mononucleosis	□	□	Other – Explain Below

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:_____
Relationship

Address: _____ Preferred 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 #*

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. All forms will be returned if the health care provider is a family member.

Information must be in English

Student's Full Name:_____

PLEASE PRINT

REQUIRED TUBERCULOSIS (TB) SCREENING

NON-US BORN STUDENTS: If you were born in a country *NOT* listed below, you MUST have a 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

ALL OTHER STUDENTS: This TB screening must be completed by a healthcare professional **AFTER APRIL 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 APRIL 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.

Signature of Health Care Provider:_____Date:_____

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

Address: _____ Fax: _____

Student's Full Name:_____

PLEASE PRINT

It is the student's responsibility to return the 4 ORIGINAL, COMPLETED, AND SIGNED Health History Record pages by August 1, 2012 for Fall Admissions, or January 15, 2013 for Spring Admissions. These 4 pages MUST be mailed. Faxes WILL NOT be accepted. All forms will be returned if the health care provider is a family member.

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 Alternatives 2-dose adolescent series Twinrix	**OR Hepatitis B Waiver signed** → → → (Must sign waiver if series is not complete at time forms are submitted to R-MC.)
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	

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)

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 7/1/07)*	**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:_____

Signature of Health Care Provider: _____Date: _____

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

Address: _____Fax:_____

PHYSICAL EXAMINATION RECORD

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

Student's Full Name: _____

PLEASE PRINT

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: _____

_____

Signature of Health Care Provider: _____ **Today's Date**:_____

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

Address: _____ **Fax:** _____