



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 Due Date: July 15, 2010 - Spring Admissions: December 1, 2010**
- Please mail All Health History Forms to the Student Health Center
Faxes will NOT be accepted
- 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.
- Medical Records and Prescriptions:** Have a record of your prescriptions, including medication strength, dosage and diagnosis/reason for treatment.
- 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>

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: _____

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

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: _____

It is the student's responsibility to return the ORIGINAL, COMPLETED Health History Record by July 15, 2010 for Fall Admissions or December 1, 2010 for Spring Admissions. This form 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	WAIVERS
Tetanus/Diphtheria Booster (required within past 10 years)		<p style="text-align: center;">Hepatitis B Waiver <i>(please check one of the boxes)</i></p> <p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> I have not completed the series of 3 vaccines but understand I must sign the waiver to complete my records.</p> <p>Student's Printed Name: _____</p> <p>Date of Birth: _____</p> <p>Signature: _____</p> <p>Date: _____ <i>(Parent/guardian's signature required if student is under the age of 18)</i></p>
<input type="checkbox"/> Td _____ OR <input type="checkbox"/> Tdap _____ <div style="text-align: center; margin-top: 5px;"> M D Y </div>		
Polio		
Completed Primary Series? <input type="checkbox"/> No <input type="checkbox"/> Yes Date last dose given _____ <div style="text-align: center; margin-top: 5px;"> M D Y </div>		
Hepatitis B		
#1 _____ #2 _____ #3 _____ OR Hepatitis B Waiver signed → → → M D Y M D Y M D Y <small>(Must sign waiver if series is not complete at time forms are submitted to R-MC.)</small> 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		

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	Meningococcal Vaccine Waiver <i>(please check one of the boxes)</i>	
Menactra <input type="checkbox"/> _____ OR Waiver signed → OR Menomune <input type="checkbox"/> M D Y (Must sign waiver if not vaccinated at time forms are submitted to R-MC) <i>(Menomune acceptable if after 7/1/07)</i>	<p><input type="checkbox"/> 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.</p> <p><input type="checkbox"/> The vaccine is not available or I have not yet been vaccinated, but understand I must sign the waiver to complete my records.</p> <p>Student's Printed Name: _____</p> <p>Date of Birth: _____</p> <p>Signature: _____ Date: _____</p>	
RECOMMENDED IMMUNIZATIONS		
Varicella (Chicken Pox) OR #1 _____ #2 _____ M D Y M D Y Serological confirmation of immunity. Attach copy of lab results. (Must be in English.)		
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		

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: _____

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: _____

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

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

Address: _____ Fax: _____