

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: <u>August 1, 2012</u> (Fall Admissions) <u>January 15, 2013</u> (Spring Admissions) <i>Faxes will NOT be accepted.</i>
	Please sign your full name at the TOP of Pages 2, 3 and 4.
	Do not use pencil to complete the Health History Form.
co	Tuberculosis (TB) Risk Assessment (page 2) is required for ALL students. Students not in impliance with <u>ALL</u> immunization requirements and TB screening for entrance to Randolph-Macon ollege 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 (HPVseries of 3 injections)
rec a p	Pre-college health examinations: Have a REQUIRED comprehensive physical examination and commended dental and eye examinations before coming to R-MC. Health Insurance: Have appropriate medical insurance and understand your coverage. This includes policy providing adequate coverage while living in Richmond, VA for services such as emergency care, 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 ength, dosage and diagnosis/reason for treatment. NOTE: We must have documentation of any
dia	ychotropic drug prescription from the diagnosing provider and office notes regarding the agnosis given. Allergy Shots: The R-MC Student Health Center administers allergy injections. A prescribing ergist's detailed orders are required. If initiating allergy shot therapy, we require the first injection be
giv ace	wen at the allergist's office. First Aid Supplies: Recommended items to bring with you to campus: digital thermometer, etaminophen, ibuprofen, cold medications, Band-Aids, topical antibacterial cream, a chemical cold ck, 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: Needed:	Completed

HEALTH HISTORY RECORD - 2012-2013

- Please mail the 4 ORIGINAL, COMPLETED, AND SIGNED Health History Record pages directly to the Student Health Center. DUE: <u>AUGUST 1, 2012</u> (Fall Admissions) <u>January 15, 2013</u> (Spring Admissions)
- Faxes will NOT be accepted

Name:	First	 Middle	Date of Birth:	// mo day yea
Permanent Address:				
Country of Birth:	C	ity	State /Country	Zip Code
Home Phone:	_	Cell Phone:		
S.S. #(Required for medical purposes)	□ Male □ Female	Expected R-MC Gra	aduation Date:	
	ORY (Please check all that apply		nswers below)	
Yes No	e dates):	s		otions ns V
Person to be notified in case of emergency: Nam	ne:		Relationshi	
Address:		Preferred Phone Number:	'	
Health Insurance Information: (please in	clude a copy of your card - f	ront and back)		
Insurance Company		Phor	ne Number	
Address	City		State	Zip
Name of Policy Holder		Individual ID	ID/Group a	 _

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.

Address: _

Information must be in English	
Student's Full Name:	
	E PRINT
REQUIRED TUBERCULOSIS (TB) SCREENING	
NON-US BORN STUDENTS: If you were born in a country NOT libegin at R-MC. American Region: Antigua and Barbuda, Barbados, Canada, Dominica, Grenada Saint Kitts and Nevis, Saint Lucia, St. Vincent & Grenadines, United States, Virgin European Region: Andorra, Austria, Belgium, Czech Republic, Cyprus, Denmarl Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, S Asian Region: no exceptions in this region Western Region: American Samoa, Australia, Cook Islands, New Zealand	a, Jamaica, Netherlands Antilles, Puerto Rico, I Islands (US and British) K, Finland, France, Germany, Greece, Iceland, Israel, Ireland, Italy,
ALL OTHER STUDENTS: This TB screening must be completed by a hea	Ithcare 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 sputum evaluation, as indicated.	including tuberculin skin testing (PPD), chest x-ray, and
2. Use the following criteria to determine if the student is a member of a ◆ Unexplained weight loss, night sweats, persistent cough > 3 weeks ◆ Ir ◆ Cough with the production of bloody sputum ◆ Healthcare worker or stu ◆ Close contact with a known case of active TB ◆ Employee or long-term ◆ 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 folken American Region: Antigua and Barbuda, Barbados, Canada, Dominica Nevis, Saint Lucia, St. Vincent & Grenadines, United States, Virgin Islanteuropean Region: Andorra, Austria, Belgium, Czech Republic, Cyprus, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, Asian Region: no exceptions in this region Western Region: American Samoa, Australia, Cook Islands, New Zeala (Based on data from 2004 World Health Organization Global TB Control Report.)	nmunosuppressive therapy ident entering a healthcare profession volunteer of a nursing home, homeless bewing: Grenada, Jamaica, Netherlands Antilles, Puerto Rico, Saint Kitts and ds (US and British) Denmark, Finland, France, Germany, Greece, Iceland, Israel, Ireland, San Marino, Sweden, Switzerland, United Kingdom
3. Using criteria in question 2 above, is student a member of a high risk of the state of the st	group?
NO IF NO, STOP. NO TUBERCULIN SKIN TEST IS REQUIRED.	
YES□ If Yes, place tuberculin skin test (PPDs placed <u>BEFORE APRI</u> Mantoux test acceptable only: 0.1 ml of PPD tuberculin containing 5 tuber.	
A history of BCG vaccination should not preclude testing. Date PPD placed:	Results in millimeters:
(<u>Record actual mm of induration</u> , transverse diameter; if no induration, record 'Interpretation (base on mm of induration, as well as risk factors): Positi	0")
Chest x-ray (required if current PPD positive or prior history of positive of tuberculin skin test.	
Date of Chest x-ray:Result: Normal	Abnormal
If chest x-ray is indicated, please attach written report and supporting do	cumentation of the positive PPD. Report must be in English.
Signature of Health Care Provider:	Date:
Please print or stamp examiner's name:	Phone:

Fax: _

Studer	nt's	Full	Nan	ne:

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 ADMII	NISTERED	WAIVERS
Tetanus/Diphtheria Booster (required	within past 10 years)		Hepatitis B Waiver
□ Td	1 1		(please check one of the boxes)
OR □Tdap			☐ I have read the information on the Web site
Polio			about Hepatitis B and the Hepatitis B vaccine. I understand the risks of the disease; however, I
	to lost doos given / /		choose not to receive the vaccine.
Completed Primary Series? ☐ No ☐ Yes Da	te last dose given//_		☐ I have not completed the series of 3 vaccines but
Hepatitis B			understand I must sign the waiver to complete my records.
#1/_/ #2/_/ #3/_/ (OR Hepatitis B Waiver s (Must sign waiver if series is n	ot complete at	Student's Printed Name:
Alternatives 2-dose adolescent series Twinrix	time forms are submitted to R-	IVIC.)	
Measles, Mumps and Rubella (MMR) (after	r first birthday and if born afte	r 1971)	Date of Birth:
MMP #1 afterfirst hirthday / /			Signature:
MMR #1 <u>after first birthday//</u>			Date:(Parent/guardian's signature required if student is
MMR #2 at least 30 days after MMR#1//_			under the age of 18)
Rubella two doses vaccine required #1// #2/_ (after first birthday and 1969) M D Y M D		firmation of immunity Must be in English.)	. Attach copy
Meningococcal Meningitis		Mening	gococcal Vaccine Waiver
Menactra □// OR W	\prime aiver signed →	`	(please check one of the boxes)
OR Menomune ☐ M D Y (Must sign waiver if no at time forms are sub (Menomune acceptable if after 7/1/07)		meningococcal m disease; however understand that in	e information on the Web site about neningitis and understand the risks of the r, I choose not to receive the vaccine. I n the event of an outbreak, unvaccinated at increased risk for contracting the illness.
RECOMMENDED IMMUNIZATIONS		Students will be a	it increased lisk for contracting the inness.
M D Y M D Y Attach copy of	nfirmation of immunity.		not available or I have not yet been nderstand I must sign the waiver to ords.
(Must be in English.) Hepatitis A		Student's Printed	Name:
#1// #2//		Date of Birth:	
Human Papilloma Virus #1// #2// #3// M _ D _ Y _ M _ D _ Y _ M _ D _ Y		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.

			PL	PLEASE PRINT			
Orug Allergies:							
Physical Exami							
-			L 20/	(1	Uncorrect	ed) R 20/ L 20/	
Hoight:		(inches)	Woight:	(nounds)	D/D·	/ Pulse:	
r leight.		(11101163)	vveignt.	(pourids)	D/F	/ F uise	
Normal	Abno	rmal		Norma	al Abnoi		
		1. HEENT				6. Genitourinary	
		2. Neck				7. Musculoskeletal	
		ĕ				ŭ	
		4. Heart				9. Skin	
		5. Abdomen					
Describe any a	hnorm	alities [.]					
Current Medica	Medications: Name of Medication		Dosage			Indication	
Dietary Require	ements	3:					
			/ity: □Unrestricted				
Recommendati	ons fo	r physical activ		□Restricte	ed		
Recommendati Explain restriction	ons fo	r physical activ	/ity : □Unrestricted	□Restricte	ed		
Recommendati Explain restriction	ons fo	r physical activ	/ity : □Unrestricted	□Restricte	ed		
Recommendati Explain restriction Other Pertinent	ons fo	r physical activ	vity: □Unrestricted	□Restricte	ed		
Recommendati Explain restriction Other Pertinent Signature of Hea	ons fo	r physical activ	vity: □Unrestricted	Restricte	ed To		