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)

1. **Health History Records**- *Required for ALL students*.
   Fall Admission due: July 11th Spring Admission Due: January 31st

2. **Please mail** the 4 original Health History Record pages with original signatures to the Student Health Center at the above address. *Faxes will NOT be accepted.*

3. **Please print** your full name at the TOP of Pages 2, 3 and 4.

4. **Do not use pencil** to complete the Health History Form.

5. **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.*

6. **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

   STRONGLY RECOMMENDED**:**

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

7. **Pre-college health examinations**: REQUIRED**:** Have a comprehensive physical examination *Strongly recommended*: dental and eye examinations before coming to R-MC.

8. **VARSITY ATHLETES**: REQUIRED**:** *sickle cell documentation or waiver signed before arriving on campus (see page 4 attached).*

9. **Health Insurance**: Federal law requires all individuals to carry health insurance.
   Contact your carrier to ensure your policy provides adequate coverage while living in Richmond, VA for services such as emergency care, lab tests, x-rays, and preventative health visits. Students should possess a copy of the insurance card at all times.

   -If you are uninsured and interested in the government's policy visit www.healthcare.gov.

   - If you are interested in the policy offered to students through Randolph-Macon, please visit our website below.

10. **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.

11. **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 – 2014-2015

- **Please mail the 4 ORIGINAL, COMPLETED, AND SIGNED Health History Record pages directly to the Student Health Center. DUE: <u>July 11</u> (Fall Admission) <u>January 31</u> (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, Granada, 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 for Fall Admissions or January 31 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

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) _____

Other Pertinent Information: _____

FOR ATHLETES ONLY

Sport(s)_____

Sickle Cell Confirmation

NCAA Requirement**: At the recommendation of the NCAA, Randolph-Macon College requires that all intercollegiate athletes must verify their sickle cell trait status prior to participation in a sport without regard to risk factors. ***Athletes will be unable to participate without this verification.

Sickle Cell Trait Positive _____ Sickle Cell Trait Negative _____ Date of Sickle Cell Testing _____

_____ _____ _____

Name of Health Care Provider Signature Date

I hereby give permission to Student Health Services to release a copy of my Immunization Record, Sickle Cell Screening Result and Physicians Health Evaluation to Randolph-Macon College Athletic Training per NCAA requirements

Student's Signature_____ Date_____

Parent or Guardian Signature (if minor) _____ Date_____

Health Care Provider: Please sign below for both athletes and non athletes.

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

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

Address: _____ **Fax:** _____