Checklist for Students and Parents
(This page is for you to keep)

1. **Health History Records** - Required for **ALL students**. (athletes, residential, commuters, and part-time)
   - Fall Admission Due: August 1st
   - Spring Admission Due: January 31st

2. **Please upload** the completed Health History Record with original signatures to the
   Patient portal: studenthealth.rmc.edu
   Faxes and Email will **NOT** be accepted.
   *If your student is under 18 at the time of check-in please complete the Authorization to Treat a Minor form attached.*
   **Make and Keep a copy of this form for your personal records**

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

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 be referred to the Dean of Students for Failure to Comply with College Policy and Required forms.**

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 (must have booster after 16 years of age)—or signed waiver declining vaccine
   - **STRONGLY RECOMMENDED:**
     - Varicella (chickenpox) or history of disease
     - Hepatitis A
     - Human Papilloma Virus (Gardasil—series of 3 injections)

7. **VARSITY ATHLETES:** **REQUIRED**: Physical Exam and sickle cell documentation or waiver signed before arriving on campus. These forms can be found on the athletic training website http://www.rmcathletics.com/information/athletictraining

8. **Health Insurance:** We **strongly recommend** all students have adequate health insurance coverage.
   **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, prescriptions and preventative health visits. Students should possess a copy of the insurance card at all times.

9. **First Aid Supplies:** Recommended items to bring with you to campus: digital thermometer, acetaminophen, ibuprofen, cold medications, Band-Aids, topical antibacterial cream, a reusable cold pack, and sunscreen.
Health History Record – 2019-2020

- **Upload** ORIGINAL, COMPLETED, AND SIGNED Health History Record pages directly to the Patient Portal (see address above).
- **DUE:** August 1 (Fall Admission) January 31 (Spring Admission)
- Please do not include forms for other departments in your upload.
- **ALL ATHLETES MUST VISIT:** http://www.rmcathletics.com/information/athletictraining in addition to completing this form.
- Faxes and Email will NOT be accepted

Name: ___________________________ Date of Birth: __/__/____

Permanent Address: ____________________________ Email: ____________________________

Country of Birth: ____________________________

Home Phone: ____________________________ Student’s Cell Phone: ____________________________

Preferred Name: ____________________________ □ Male □ Female Expected R-MC Graduation Date: ____________________________

**MEDICAL HISTORY** (Please check all that apply and explain any "Yes" answers below)

- □ Allergies (annual/seasonal)
- □ Anemia
- □ Asthma/Exercise-Induced Asthma
- □ Bone/Joint Disorder
- □ Cancer
- □ Chicken Pox
- □ Circulatory Problems/Blood Clots
- □ Convulsions/Seizures/Epilepsy
- □ Diabetes
- □ Eating Disorders
- □ Gastrointestinal Problems
- □ Gynecological Problems
- □ Frequent Headaches
- □ Heart Disease
- □ Hepatitis/Liver Disease
- □ Mental Health (depression/anxiety/other)
- □ Mononucleosis
- □ Rheumatic Fever
- □ Tuberculosis
- □ Sexually Transmitted Diseases
- □ Elevated Cholesterol
- □ High Blood Pressure
- □ Frequent Throat Infections
- □ Frequent Ear Infections
- □ ADD/ADHD
- □ Other – Explain Below

**Current Weight:** __________  **Current Height:** __________

Current Diagnosis, Medications and Dosage:
__________________________________________________________

Allergies: medication/foods, etc. (include reaction)
__________________________________________________________

Significant illness/hospitalization/surgery (include dates):
__________________________________________________________

History of psychiatric/psychological condition (ex: anxiety 1/12-present)
__________________________________________________________

**Health Insurance Information:**

**Person to be notified in case of emergency:** Name: ____________________________ Relationship: ____________________________

Address: ____________________________ Preferred Phone Number: ____________________________

**Insurance Company**

__________________________________________________________

**Phone Number**

__________________________________________________________

**Address**

__________________________________________________________

**Name of Policy Holder**

__________________________________________________________

**Individual ID**

__________________________________________________________

**ID/Group #**

__________________________________________________________

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Tuberculosis Risk Assessment (TBRA)
Student completes upon entrance or within 6 months of re-entrance to the College

1. Have you ever had a positive tuberculosis (TB) test? NO _____ YES _____ * If you have had a positive TB test in the past, you must submit documentation of the positive test, including chest x-ray report and treatment records. Further testing may not be required.

2. Do you have any of the following signs or symptoms of active TB disease? NO _____ YES _____
   o Unexplained fever/chills for more than 1 week
   o Persistent cough of unknown etiology for more than 3 weeks
   o Cough with bloody sputum
   o Night sweats
   o Unexplained weight loss
   o Unexplained fatigue

3. Do any of the following situations apply to you? NO _____ YES _____
   o Close contact with a person known or suspected to have TB
   o Use of any illegal injectable drugs
   o At risk for Human Immunodeficiency Virus (HIV) infection
   o Volunteered, resided, or worked in a healthcare facility or congregate living setting (homeless shelter, nursing home, or correctional facility) for longer than 1 month
   o History of silicosis, diabetes, renal disease, blood disorders or cancer
   o History of gastrectomy, jejunolilieal bypass, or chronic malabsorptive condition
   o History of a solid organ transplant (kidney, heart, liver)
   o Immunosuppressive therapy, such as prolonged corticosteroid therapy, chemotherapy
     Or TNF-antagonist medications (Humira, Embrel, Remicad)
   o Are less than 10% of normal body weight or malnourished

4. Within the past 5 years, have you traveled to or lived in any of the following areas for more than one month? NO __YES ___
   Africa, Asia, Central America, Cuba, Dominican Republic, Eastern Europe, Haiti, India and other Indian subcontinent nations, Middle East (except Egypt, Saudi Arabia, Jordan, Lebanon, UAE), Portugal, South America, South Pacific (except Australia and New Zealand).

If you answered “yes” to any question above, TB testing is required.

If you have questions regarding testing for TB please contact the Student Health Center (804) 752-3041. Your options for testing are as follows:

1. Have the test done as soon as possible with your health care provider, prior to coming to the College. It may take several weeks for the results to be sent to us, do not delay testing. Submit a copy of the written report to the Student Health Center.

2. Have the test done at the SHC during Orientation Week. The SHC will be open 8:00 am until 4:00 pm Monday - Friday. The cost of the test will be billed to your student account.

Test Used: __________________________  Date Placed: ________________  Date Read: __________________________
Result: _______ Positive  _______ Negative  CXR indicated _______ YES _______ NO
Health Care Provider Name: __________________________________________________________
Signature __________________________________________________________ Phone: ____________

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Please print

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.

Information must be in English.

Virginia State Law and Randolph-Macon College
Require the Following Immunizations

A) MMR (Measles, Mumps, Rubella)
   Two doses live vaccine required at or after 12 months of age, at least one month apart
   Dose #1 _____/____/____
   Dose #2 _____/____/____
   If vaccinated separately:
   Measles Dose #1 _____/____/____
   Mumps Dose #2 _____/____/____
   Rubella Dose #1 _____/____/____

B) TETANUS/DIPHTHERIA/PERTUSSIS (Tdap) or TETANUS/DIPHTHERIA (TD)
   This booster date must be within last 10 years:
   _____/____/____

C) MENINGOCOCCAL VACCINE (ACYW-135)
   This booster date must be after student turns 16:
   _____/____/____
   (or sign waiver – see next page)

D) HEPATITIS B VACCINE
   (3 doses required)
   Dose #1 _____/____/____
   Dose #2 _____/____/____
   Dose #3 _____/____/____
   (or sign waiver – see next page)

E) POLIO VACCINE
   Last Dose _____/____/____

RECOMMENDED IMMUNIZATIONS

a. HEPATITIS A VACCINE
   2 doses vaccine given at 0, 6-12 months
   Dose #1 _____/____/____
   Dose #2 _____/____/____

b. HUMAN PAPILLOMAVIRUS VACCINE (HPV)
   3 doses at 0, 2, and 6 month intervals
   Dose #1 _____/____/____
   Dose #2 _____/____/____
   Dose #3 _____/____/____
   Mo Day Yr

   Or History of Disease _____/____/____

   ★ Verified by: Health Care Provider’s Signature: ________________________________
   Name Printed: ____________________________________________________________
   Address: ________________________________________________________________
   Phone: ________________________________

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INFORMATION REGARDING HEPATITIS B AND MENINGOCOCCAL MENINGITIS DISEASE AND IMMUNIZATION

In compliance with Virginia state law, Randolph-Macon College requires that all incoming full-time students be vaccinated against meningococcal disease and Hepatitis B disease OR sign a waiver indicating they have received information about these diseases, the availability and effectiveness of the vaccines and choose not to be vaccinated.

**HEPATITIS B** is a serious infection of the liver caused by the Hepatitis B virus. The Hepatitis B virus (HBV) may cause lifelong infection, cirrhosis of the liver, liver cancer, liver failure and death. Hepatitis B is transmitted through infected body fluids such as blood, semen, and vaginal secretions; infection may occur through mucous membranes and broken skin. Most commonly, Hepatitis B is transmitted by sexual contact. It may also be spread by exposure to blood through contact sports, repeatedly sharing an infected person's razor, toothbrush, or earrings, travel to a high-risk area, use of illicit injectable drugs or through contaminated needles use for tattooing or piercing. The Hepatitis B vaccine is safe and effective. The vaccine is generally a series of three doses given over a period of 6 months, although the series never has to be re-started if the schedule is interrupted.

**HEPATITIS B VACCINE WAIVER**
I have reviewed the information provided on the risks associated with Hepatitis B disease, and the effectiveness of any vaccine against Hepatitis B disease and I choose not to be vaccinated at this time.

__________________________________________________
Signature of student or Legal Guardian if under age 18 Date

**MENINGOCOCCAL DISEASE** is a potentially fatal bacterial infection caused by the organism Neisseria meningitis. Although meningococcal disease is relatively rare, the initial flu-like symptoms may make diagnosis difficult. The disease may lead to brain damage, vital organ failure, permanent disability or death. Studies indicate college students living in residence halls, especially freshmen residents, are at increased risk of infection.

**MENINGOCOCCAL VACCINE WAIVER**
I have reviewed the information provided on the risks associated with Meningococcal disease, and the effectiveness of any vaccine against Meningococcal disease and I choose not to be vaccinated at this time.

______________________________________________
Signature of student or Legal Guardian if under age 18 Date
AUTHORIZATION FOR CONSENT TO TREATMENT OF MINOR

(I), (We), the undersigned, parent(s) or legal guardian of _____________________
a minor, do hereby authorize Randolph-Macon College Student Health
as agent(s) for the undersigned to consent to any diagnostic testing, examinations, anesthetics medical or
surgical diagnosis or treatments and/or hospital care which is deemed advisable by and is to be rendered under
the general or special supervision of any licensed medical provider.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care
being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific
consent to any/all such diagnosis, treatment or hospital care which the aforementioned medical provider(s) in
the exercise of his best judgment may deem advisable.

This authorization shall remain effective until the Student becomes of age at 18.

Date:____________________  Parent:___________________________________

Legal Guardian:____________________________

Birthdate:______________

Allergies to Drugs or Foods:___________________________________________

Current Medications:____________________________________________________

Current Medical or Mental Health Problems:_______________________________

Student’s Health Care Provider:________________________ Provider’s Phone#________________

____________________________________________________________________

Father/Guardian Signature            Home Phone            Business Phone

____________________________________________________________________

Mother/Guardian Signature            Home Phone            Business Phone