



**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. (athletes, residential, commuters, and part-time)*  
Fall Admission Due: August 1st      Spring Admission Due: January 31<sup>st</sup>

2. **Upload** the completed Health History Record/Form to your secure patient portal.  
**Do not mail, email or fax the form. You must PRINT the form, fill it out, then upload it. DONOT attempt to fill out and sign the form electronically. Patient portal: studenthealth.rmc.edu**

*If the student is under 18 at the time of check-in please complete and upload the Authorization to Treat a Minor  
\*\*Make and Keep a copy of this form for your personal records\*\**

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

4. **VARSITY ATHLETES:** This Health Form must be uploaded to the student health portal: [studenthealth.rmc.edu](http://studenthealth.rmc.edu) You can find athletic participation requirements here: [Randolph-Macon \(prestosports.com\)](http://Randolph-Macon.prestosports.com). (copy and paste as hyperlink into your browser)

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)
- COVID-19 Vaccination

7. **Health Insurance:** We strongly recommend all students have adequate health insurance coverage while living in Richmond, VA. Students should always carry a copy of the insurance card.

8. **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.



**Student Health Center**  
 PO Box 5005 Ashland VA 23005  
**Phone:** (804)752-3041  
**Email:** studenthealth@rmc.edu  
**Patient Portal:** studenthealth.rmc.edu

## HEALTH HISTORY RECORD – 2023-2024

- **Upload** Health History Record pages directly to the Patient Portal: **studenthealth.rmc.edu**  
**DUE: August 1 (Fall Admission) January 31 (Spring Admission)**
- Do not include forms for other departments in your upload. Do not mail, email or fax this form.

**Varsity Athletes must upload this Health History Form into the student portal: studenthealth.rmc.edu AND follow the instructions on the athletics page: [Randolph-Macon \(prestosports.com\)](http://Randolph-Macon.prestosports.com) (copy and paste hyperlink)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Permanent Address: \_\_\_\_\_  
Last First Middle mo day year  
Street City State /Country Zip Code

Country of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Student's Cell Phone: \_\_\_\_\_ Student ID #: \_\_\_\_\_

Preferred Name: \_\_\_\_\_  Male  Female Expected **R-MC** Graduation Date: \_\_\_\_\_

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

- |   |   |  |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
|---|---|--|-----------------------|--|---|--|---------------------------------|--|---------------------------------------|---|---|--|--|---|---|---------------------------------|--|--|--------------------------------------|--|---|---|--|--|--|---|-----------------------------------|-----------------------------------|--|--|--|--|
| <table border="0"> <tr><td><small>Yes No</small></td><td><small>Yes No</small></td><td><small>Yes No</small></td></tr> <tr> <td><input type="checkbox"/> Allergies (annual/seasonal)</td> <td><input type="checkbox"/> Eating Disorders</td> <td><input type="checkbox"/> Rheumatic Fever</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Gastrointestinal Problems</td> <td><input type="checkbox"/> Tuberculosis</td> </tr> <tr> <td><input type="checkbox"/> Asthma/Exercise-Induced Asthma</td> <td><input type="checkbox"/> Gynecological Problems</td> <td><input type="checkbox"/> Sexually Transmitted Diseases</td> </tr> <tr> <td><input type="checkbox"/> Bone/Joint Disorder</td> <td><input type="checkbox"/> Frequent Headaches</td> <td><input type="checkbox"/> Elevated Cholesterol</td> </tr> <tr> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Heart Disease</td> <td><input type="checkbox"/> High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> Chicken Pox</td> <td><input type="checkbox"/> Hepatitis/Liver Disease</td> <td><input type="checkbox"/> Frequent Throat Infections</td> </tr> <tr> <td><input type="checkbox"/> Circulatory Problems/Blood Clots</td> <td><input type="checkbox"/> Kidney/Urinary Problems</td> <td><input type="checkbox"/> Frequent Ear Infections</td> </tr> <tr> <td><input type="checkbox"/> Convulsions/Seizures/Epilepsy</td> <td><input type="checkbox"/> Mental Health (depression/anxiety/other)</td> <td><input type="checkbox"/> ADD/ADHD</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Mononucleosis</td> <td><input type="checkbox"/> Other – Explain Below</td> </tr> </table> | <small>Yes No</small>   | <small>Yes No</small>                                  | <small>Yes No</small> | <input type="checkbox"/> Allergies (annual/seasonal) | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma/Exercise-Induced Asthma | <input type="checkbox"/> Gynecological Problems | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Bone/Joint Disorder | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Frequent Throat Infections | <input type="checkbox"/> Circulatory Problems/Blood Clots | <input type="checkbox"/> Kidney/Urinary Problems | <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Convulsions/Seizures/Epilepsy | <input type="checkbox"/> Mental Health (depression/anxiety/other) | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other – Explain Below |  |  |
| <small>Yes No</small>   | <small>Yes No</small>   | <small>Yes No</small>                                  |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Allergies (annual/seasonal)  | <input type="checkbox"/> Eating Disorders                         | <input type="checkbox"/> Rheumatic Fever               |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Anemia   | <input type="checkbox"/> Gastrointestinal Problems                | <input type="checkbox"/> Tuberculosis                  |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Asthma/Exercise-Induced Asthma   | <input type="checkbox"/> Gynecological Problems                   | <input type="checkbox"/> Sexually Transmitted Diseases |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Bone/Joint Disorder  | <input type="checkbox"/> Frequent Headaches                       | <input type="checkbox"/> Elevated Cholesterol          |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Cancer   | <input type="checkbox"/> Heart Disease                            | <input type="checkbox"/> High Blood Pressure           |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> Hepatitis/Liver Disease                  | <input type="checkbox"/> Frequent Throat Infections    |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Circulatory Problems/Blood Clots   | <input type="checkbox"/> Kidney/Urinary Problems                  | <input type="checkbox"/> Frequent Ear Infections       |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Convulsions/Seizures/Epilepsy  | <input type="checkbox"/> Mental Health (depression/anxiety/other) | <input type="checkbox"/> ADD/ADHD                      |                       |  |   |  |                                 |  |                                       |   |   |  |  |   |   |                                 |  |  |                                      |  |   |   |  |  |  |   |                                   |                                   |  |  |  |  |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Mononucleosis                            | <input type="checkbox"/> 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 \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Individual ID \_\_\_\_\_ ID/Group # \_\_\_\_\_

Student's Full Name: \_\_\_\_\_

PLEASE PRINT

## Tuberculosis Risk Self-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 \_\_\_

- Unexplained fever/chills for more than 1 week
- Persistent cough of unknown etiology for more than 3 weeks
- Cough with bloody sputum
- Night sweats
- Unexplained weight loss
- Unexplained fatigue

3. **Do any of the following situations apply to you?** NO \_\_\_ YES \_\_\_

- Close contact with a person known or suspected to have TB
- Use of any illegal injectable drugs
- At risk for Human Immunodeficiency Virus (HIV) infection
- Volunteered, resided, or worked in a healthcare facility or congregate living setting (homeless shelter, nursing home, or correctional facility) for longer than 1 month
- History of silicosis, diabetes, renal disease, blood disorders or cancer
- History of gastrectomy, jejunioileal bypass, or chronic malabsorptive condition
- History of a solid organ transplant (kidney, heart, liver)
- Immunosuppressive therapy, such as prolonged corticosteroid therapy, chemotherapy  
Or TNF-antagonist medications (Humira, Embrel, Remicade)
- 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).

Student Signature (or guardian if under 18) : \_\_\_\_\_ Date: \_\_\_\_\_

**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: \_\_\_\_\_



Student's Full Name: \_\_\_\_\_

PLEASE PRINT

Immunization dates must be verified by a health care provider **OR** an immunization transcript from a physician's office can be provided.

Information must be in English

**Virginia State Law and Randolph-Macon College  
Require the Following Immunizations(A-E)**

**A) MMR (Measles, Mumps, Rubella)**

Dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Two doses live vaccine required at or after 12 months of age, at least one month apart

Dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If vaccinated separately:

Measles Dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dose # 2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Mumps Dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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 or sign waiver – see next page)

Dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dose #3 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**E) POLIO VACCINE**

Last Dose \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**RECOMMENDED IMMUNIZATIONS**

**\*1-4 below not required but recommended**

**1. HEPATITIS A VACCINE**

2 doses vaccine given at 0, 6-12 months

Dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**2. HUMAN PAPILOMAVIRUS VACCINE (HPV)**

3 doses at 0, 2, and 6 month intervals

Dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dose #3 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Mo Day Yr

**3. COVID-19 VACCINE**

Dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Circle one: J&J Pfizer Moderna

Dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Circle one: J&J Pfizer Moderna

Last Booster \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Circle one: Pfizer Moderna

**4. VARICELLA VACCINE**

**\*STRONGLY RECOMMENDED\***

Two doses of vaccine one month apart

Dose #1 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Dose #2 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Mo Day Yr

Or History of Disease \_\_\_\_ / \_\_\_\_ / \_\_\_\_

➡ Verified by : Health Care Provider's Signature: \_\_\_\_\_

Name Printed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Student's Full Name: \_\_\_\_\_

*PLEASE PRINT*

## WAIVER DOCUMENT

### 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 meningitidis*. 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



**RANDOLPH-MACON**  
C O L L E G E

**AUTHORIZATION FOR CONSENT TO TREATMENT OF MINOR**

(Complete if student is under 18)

(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