

# RANDOLPH COLLEGE MEDICAL RECORD

(Medical History: pages 1 & 2, Physician Physical page 3, Immunization Form page 4)

For students living in Residence Halls

**DEADLINE:** First Semester Admits **AUGUST 1**; Second Semester Admits **JANUARY 10**

This record must be **completed and mailed in its entirety directly** to: **Randolph College  
Health Center  
2500 Rivermont Avenue  
Lynchburg, VA 24503-1555**

The information supplied will be used by the Health and Counseling Centers staff to provide necessary health and mental health care while you are enrolled here. This information will not be released without your written consent. In the case of a student athlete, the Physician Physical will be released to the athletic training staff.

## MEDICAL HISTORY (to be completed by student)

Last Name (please print)		First Name	Middle Name	Social Security Number		
_____			Male _____	Female _____		
Birth Date						
_____						
Home Address (number and street)		City or Town	State	Zip or Postal Code		
_____						
Country				Home Phone Number		
_____						
Person to notify in case of an emergency		Relationship	Address			
_____						
Phone: Home		Business	Cell			
_____						
Admissions Status		( ) First-Year	( ) Transfer	( ) Readmission	( ) Special	_____ Year of Entrance

### Health Insurance

**Health Insurance is required for all full time students while attending Randolph College. Students are automatically enrolled in the College Plan and will be billed accordingly. However, you may decline this coverage and have the charge removed from your account by completing the online Waiver Form by the specified deadline.**

### Permission for Treatment

The College's Student Health Center has my permission to perform or authorize routine medical care and to make referrals to area specialists and medical services. Under certain circumstances, the student may be transported to an area hospital for diagnosis and treatment.

In the event of emergency medical care, every effort will be made to contact a parent or legal guardian.

**This form must be signed by the student.** If the student is a minor (under 18 years of age), this form must also be signed by the parent or legal guardian so that appropriate diagnosis and treatment may be promptly carried out. No major health services will be performed, except in an emergency, without a parent or legal guardian being contacted and fully informed if the student is a minor.

Student Signature		Date
_____		_____
Signature of Parent or Guardian (if student is a minor)	Relationship	Date
_____	_____	_____

## Family Health History

Have any of your immediate relatives (father, mother, siblings) ever had any of the following? Please specify.

	Relationship		Relationship		Relationship		Relationship
Allergies		Diabetes		Stomach Disease		Eating Disorder	
Arthritis		Epilepsy		Stroke		Depression	
Blood Disorders		Heart Disease		Tuberculosis		Bipolar	
Cancer		Hypertension		Alcoholism		Anxiety	
Death		Kidney Disease		Drug Addiction		Schizophrenia	

## Personal Health History

Have you ever been admitted to a hospital or residential treatment center for any surgical procedure, illness, infection, injury, or condition? Please state when, where, and what for each hospitalization.

Have you been treated for a psychological, psychiatric, substance abuse, or personal problem? Give details.

### Allergies

**No known allergies**     
  Aspirin     
  Penicillin     
  Codeine     
  Sulfa  
 Other Drugs (please specify) \_\_\_\_\_  
 Insect     
  Food     
  Other (please specify) \_\_\_\_\_

### Medications

If you take any medications orally or by injection on a frequent or regular basis, please list them and indicate dosage and frequency.

### Disability

**None**

Do you have an impairment that substantially limits a major life activity, or are you disabled in any way that requires you to receive special consideration from the College? If so, please check the appropriate box and give specifics.

Vision     
  Hearing     
  Speech     
  Motor     
  Anatomical loss (please specify) \_\_\_\_\_

Please explain disability \_\_\_\_\_

This information on disability will be shared with the Office of the Dean of Students and other appropriate College offices, as necessary.

### Medical History (check each item Yes or No)

<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> Allergies	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> Eating disorders	<input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>	<input type="checkbox"/> Hepatitis
<input type="checkbox"/>	<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/> Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/> High blood pressure
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Emotional problems	<input type="checkbox"/>	<input type="checkbox"/> Kidney/Urinary problems
<input type="checkbox"/>	<input type="checkbox"/> Bone/Joint disorder	<input type="checkbox"/>	<input type="checkbox"/> Fainting spells	<input type="checkbox"/>	<input type="checkbox"/> Liver disease
<input type="checkbox"/>	<input type="checkbox"/> Breast disorder	<input type="checkbox"/>	<input type="checkbox"/> Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/>	<input type="checkbox"/> Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/> Frequent throat infections	<input type="checkbox"/>	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/> Concussions/Unconsciousness	<input type="checkbox"/>	<input type="checkbox"/> Gastrointestinal problems	<input type="checkbox"/>	<input type="checkbox"/> Sickle cell
<input type="checkbox"/>	<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/> Gynecological/Menses problems	<input type="checkbox"/>	<input type="checkbox"/> Smoker
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> Heart disease/Murmur	<input type="checkbox"/>	<input type="checkbox"/> Substance abuse/Alcohol abuse

REMARKS OR ADDITIONAL INFORMATION \_\_\_\_\_

I, \_\_\_\_\_, certify that the enclosed information I have provided is truthful, accurate and complete to the best of my knowledge.

Signature Required

**RANDOLPH COLLEGE PHYSICIAN PHYSICAL**  
**For athletes and students living in Residence Halls**

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PHYSICIAN PHYSICAL**

**TO THE EXAMINING PHYSICIAN:** Please complete the Physical Examination, PPD screening/test and immunization requirements. This information is strictly for the use of the Health and Counseling Centers and Athletic Trainer and will not be released without student consent. **All information must be in English. These forms must be completed prior to the student's arrival on campus.**

Temperature \_\_\_\_\_ Height (inches) \_\_\_\_\_ Weight (lbs) \_\_\_\_\_ Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Corrected Vision: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_  
 Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

Urinalysis: Sugar: \_\_\_\_\_ Hemoglobin: \_\_\_\_\_  
 Protein: \_\_\_\_\_ or \_\_\_\_\_  
 Blood: \_\_\_\_\_ Hematocrit: \_\_\_\_\_  
 Micro (if indicated): \_\_\_\_\_

	Normal	Abnormal	If abnormal, describe fully
Head, eyes, ears, nose, or throat			
Neck			
Respiratory			
Cardiovascular			
Genitourinary			
Gastrointestinal			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

- A. Please list all problems obtained from the student's medical history and physical examination.
  
- B. Recommendation for physical activity (P.E., team sports) \_\_\_Unlimited \_\_\_Limited Explain:
  
- C. Do you have any recommendations regarding the care of the student? \_\_\_Yes \_\_\_No Explain:
  
- D. Is the student now under treatment for any medical condition? \_\_\_Yes \_\_\_No Explain:
  
- E. Current medications and dosages:
  
- F. Has the student ever had treatment or counseling for an emotional, behavioral, or psychological condition (including eating disorders and/or substance abuse)? \_\_\_Yes \_\_\_No Explain:

If the answer is yes to D and/or F, a full medical report from the physician, psychiatrist, certified therapist, or counselor is requested. (A full report will include a statement of the problem (diagnosis), treatment, response to treatment, and need for follow-up.) This report should be directed to the College Health and Counseling Centers. This report will not be released without the written consent of the student.

Physician's Signature \_\_\_\_\_  
 Address: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

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

Print Last Name \_\_\_\_\_ Date \_\_\_\_\_

**Please mail to:**  
 Randolph College  
 Health Center  
 2500 Rivermont Avenue  
 Lynchburg, VA 24503-1555  
 Phone: 434-947-8130  
 Fax: 434-947-8106

**RANDOLPH COLLEGE IMMUNIZATION FORM**  
**For students living in Residence Halls**

Name \_\_\_\_\_ Date of Entry \_\_\_\_\_ Date of Birth \_\_\_\_\_

**To be completed and signed by your health care provider. All information must be in English.**

**REQUIRED IMMUNIZATIONS**

MMR (Measles, Mumps, Rubella) Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Two doses live vaccine at or after 12 months of age, at least one month apart Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

DIPHTHERIA/PERTUSSIS/TETANUS (DPT)  
 1. Primary childhood series date completed \_\_\_\_/\_\_\_\_/\_\_\_\_  
 2. Tetanus/Diphtheria: Td or Tdap (**circle**) Booster **within last 10 years** \_\_\_\_/\_\_\_\_/\_\_\_\_

POLIO SERIES: Primary childhood series date completed \_\_\_\_/\_\_\_\_/\_\_\_\_

MENINGOCOCCAL VACCINE: \_\_\_\_/\_\_\_\_/\_\_\_\_

HEPATITIS B VACCINE Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (Series of 3 vaccines) Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dose 3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo Day Yr

TUBERCULOSIS SCREENING within last 12 months  
 PPD is strongly recommended, however, CDC guidelines allow the following screening alternative:

- TB Risk Assessment:**
1. Does the student have signs or symptoms of active TB disease? YES NO (**circle**)  
 (fatigue, unexplained weight loss, loss of appetite, night sweats, chronic cough, hemoptysis, chest pain)
  2. Is the student a member of a high-risk group? YES NO (**circle**)  
 (Plans to enter health care profession; known exposure to HIV infection; contact with person infected with TB; IV drug user; has resided or worked in homeless shelter, prison, nursing home, hospital, other health care facility; history of silicosis, diabetes, chronic renal failure, hematologic disorders, cancer, low body weight, gastric bypass, prolonged corticosteroid or other immunosuppressive therapy; **or within the past 5 years traveled to or lived in any country other than the USA or Canada**)

**If NO to all above, student is considered low risk and no further evaluation is needed.**

**If YES to any of the above, PPD REQUIRED.**

PPD (Mantoux) (within the past 12 months) Placement Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Result \_\_\_\_\_ mm Negative Positive (**circle**) Assessment/Reading Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**IF PPD IS POSITIVE, CHEST X-RAY AND COPY OF REPORT REQUIRED.**

**RECOMMENDED IMMUNIZATIONS**

VARICELLA VACCINE If no history of Chicken Pox (Disease date) \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 At least one month after first dose, if age 13 years or older Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

GARDISIL Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ 2 \_\_\_\_/\_\_\_\_/\_\_\_\_ 3 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Health Care Provider**

Physician's Signature \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

Print Last Name \_\_\_\_\_ Date \_\_\_\_\_

**Please mail to:**

Randolph College  
 Health Center  
 2500 Rivermont Avenue  
 Lynchburg, VA 24503  
 Phone: 434-947-8130  
 Fax: 434-947-8106