

RANDOLPH COLLEGE HEALTH FORM

DEADLINE: First Semester Admits **JULY 1**; Second Semester Admits **JANUARY 1**

This Health Form is to be completed and mailed directly to **Randolph College, Health Center, 2500 Rivermont Avenue, Lynchburg, VA 24503-1555**. The information supplied will be used only 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.

PART A: MEDICAL HISTORY (to be completed by student)

Last Name (please print)	First Name	Middle Name	Social Security Number
Birth Date		Male _____	Female _____

Home Address (number and street)	City or Town	State	Zip or Postal Code
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Country	Home Phone Number
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Person to notify in case of an emergency	Relationship	Address
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Phone: Home	Business	Cell
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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. New 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.

Randolph College Insurance _____yes	Own Insurance: _____ <div style="text-align: right; margin-left: 400px;">Company Name</div> <hr/> Guarantor's Name Guarantor's Date of Birth <hr/> Guarantor's Employer
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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
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Signature of Parent or Guardian (if student is a minor)	Relationship	Date
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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"/> <input type="checkbox"/> Allergies	<input type="checkbox"/> <input type="checkbox"/> Eating disorders	<input type="checkbox"/> <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"/> Chickenpox	<input type="checkbox"/> <input type="checkbox"/> Frequent throat infections	<input type="checkbox"/> <input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> <input type="checkbox"/> Circulatory problems	<input type="checkbox"/> <input type="checkbox"/> Gastrointestinal problems	<input type="checkbox"/> <input type="checkbox"/> Smoker
<input type="checkbox"/> <input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> <input type="checkbox"/> Gynecological problems	<input type="checkbox"/> <input type="checkbox"/> Substance abuse
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Heart disease	<input type="checkbox"/> <input type="checkbox"/> 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

Student's Name _____ Date of Birth _____

PART B: 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 will not be released without student consent. **All information must be in English. Registration may be withheld until these forms are returned with documentation of required immunizations.**

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

Urinalysis: Sugar: _____ Hemoglobin: _____ Pap Smear (optional): _____
 Albumin: _____ or _____ Date of last Pap Smear: _____
 Other: _____ Hematocrit: _____ Results: _____
 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
RESIDENTIAL STUDENT IMMUNIZATION FORM**

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: Menomune or Menactra (**circle**) ____/____/____

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 recommended for females 9-26 years of age Dose 1 ____/____/____ 2 ____/____/____ 3 ____/____/____

Health Care Provider

Physician's Signature _____

Address: _____

Phone: _____ Fax: _____

Print Last Name _____ Date _____

Please mail to:

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