

**RANDOLPH COLLEGE
MEDICAL RECORD**

For Day and Prime Time students living off campus

DEADLINE: First Semester Admits **August 1**; Second Semester Admits **January 10**

This form must be completed and on file prior to arrival on campus.

Name _____
Address _____
Phone (____) _____ Date of Birth _____ Date of Enrollment _____
Allergies (medications, bee stings, foods, etc.) _____
Randolph College Insurance ___ yes Own Insurance (Company name) _____

REQUIRED IMMUNIZATIONS

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

According to the Centers for Disease Control and American College Health Association: those born before 1957 without other evidence of immunity should receive **one dose** if not in an outbreak setting and **two doses** if in an outbreak.

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 ____/____/____
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 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 (Chickenpox) strongly recommended if no history of disease

Birth in the United States before 1980, a history of chickenpox, a positive varicella antibody, or immunization meets the requirement.
History of Disease Yes____ No____ Vaccinated 1____/____/____ 2____/____/____/ (Doses 4-8 weeks apart)

HEPATITIS B strongly recommended Dose 1____/____/____ 2____/____/____ 3____/____/____

MENINGOCOCCAL VACCINE: ____/____/____

Only recommended for non-residential students under the age of 25 who choose to be vaccinated to reduce risk of meningococcal disease

Health Care Provider

Name _____
Signature _____
Address _____
Phone (____) _____ Date _____

Please return form to:
Randolph College
Health Center
2500 Rivermont Avenue
Lynchburg, VA 24503