RANDOLPH COLLEGE MEDICAL RECORD

Required for **ALL FULL-TIME** incoming students

DEADLINE: Fall semester admits: **AUGUST 1** Spring semester admits: **JANUARY 1**

This record must be completed and mailed by the due date in its entirety **directly to**:

Randolph College Health Center, 2500 Rivermont Avenue, Lynchburg, VA 24503-1526

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.

DEMOGRAPHICS AND MEDICAL HISTORY (to be completed by student – PLEASE PRINT CLEARLY)

Name (Last, First, Middle):_____ Social Security Number: _____

Date of Birth (MM/DD/YYYY): _____ Gender: _____ Cell Phone: _____

Home Address (number and street, city, state, zip code): _____

Country (if outside of United States): _____

Person to notify in case of an emergency: _____ Relationship: _____

Emergency Contact Phone Numbers (Please include all numbers where this person can be reached): _____

HEALTH INSURANCE

Health Insurance is **required** for all **full-time students** while attending Randolph College. Students must complete the online waiver providing proof of health insurance or enroll in the College-sponsored health insurance plan (and will be billed accordingly). The **deadline** to complete the online waiver is **August 15** for Fall semester new and returning students and **January 27** for Spring semester new and readmitted students.

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, I understand that I, the student, may be transported to an area hospital for diagnosis and treatment.

If emergency medical care is necessary, 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		Seizures		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 medical condition? Please state when, where, and what for each hospitalization.

_____

_____

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

_____

_____

Allergies NO KNOWN ALLERGIES _____

Medications, including over-the-counter and prescription (please specify): _____

Insects: _____ Foods:_____ 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: _____

Access Requirements

_____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 need _____

This information 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)

Yes	No		Yes	No		Yes	No	
___	___	Allergies	___	___	Eating disorders	___	___	Hepatitis
___	___	Anemia	___	___	Elevated cholesterol	___	___	High blood pressure
___	___	Asthma	___	___	Emotional problems	___	___	Kidney/Urinary problems
___	___	Bone/Joint disorder	___	___	Fainting spells	___	___	Liver disease
___	___	Breast disorder	___	___	Frequent ear infections	___	___	Mononucleosis
___	___	Cancer	___	___	Frequent headaches	___	___	Rheumatic fever
___	___	Circulatory problems	___	___	Frequent throat infections	___	___	Sexually transmitted disease
___	___	Concussions/Unconsciousness	___	___	Gastrointestinal problems	___	___	Sickle cell
___	___	Convulsions/Seizures	___	___	Gynecological/Menses problems	___	___	Smoker
___	___	Diabetes	___	___	Heart disease/Murmur	___	___	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 (please provide your signature in the space above).

RANDOLPH COLLEGE PHYSICAL FORM (must be completed on this form)

Student's Name: _____ Date of Birth: _____

TO THE EXAMINING MEDICAL PROVIDER: **Please complete BOTH PAGES 3 AND 4 (Randolph College Physical, and Immunizations and TB Screening/PPD testing)**. 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_____ Pulse_____ Blood Pressure_____

Urinalysis (if medically indicated): Hgb/Hct (if medically indicated): _____ Height (ft/in) _____ Weight (lbs)_____
Sugar: Protein:
Blood: 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 If yes, please 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.

Provider's Printed Name and Signature: _____

Office Address: _____Office Phone:_____

PLEASE RETURN FORMS TO STUDENT. IF UNABLE TO RETURN TO STUDENT, PLEASE FAX TO: 434-947-8106 or MAIL TO: Randolph College Health Center, 2500 Rivermont Avenue, Lynchburg, VA 24503

RANDOLPH COLLEGE IMMUNIZATION FORM

To be completed and signed by your health care provider. All information must be in English and in the MM/DD/YYYY format.

Name_____ Year of Entry_____ Date of Birth_____

REQUIRED IMMUNIZATIONS

*You will not be allowed on campus or in residence halls without documentation of the required immunizations transcribed by your provider onto this form. Please email the Director of Health Services at rbryant@randolphcollege.edu if you have questions or special circumstances. Please do not wait until your arrival at Randolph College to discuss missing documentation or immunizations.

MEASLES/MUMPS/RUBELLA (MMR): Dose 1 ___/___/_____ Dose 2___/___/_____
(Two doses of MMR at least 28 days apart with first dose given after 12 months of age)

DIPHTHERIA/TETANUS/PERTUSSIS (DTP): Primary childhood series date completed ___/___/_____

TETANUS/DIPHTHERIA BOOSTER (Td/Tdap): Must be dated within last 10 years ___/___/_____

POLIO (IPV/OPV): Primary childhood series date completed ___/___/_____

MENINGITIS MCV-4 VACCINE (Menactra/Menveo): Must be dated on or after age 16 ___/___/_____

HEPATITIS B VACCINE: Dose 1 ___/___/_____ Dose 2___/___/_____ Dose 3___/___/_____

VARICELLA VACCINE Dose 1___/___/_____ Dose 2 ___/___/_____
(Two doses of Varicella at least 12 weeks apart if given between 1 and 12 years of age, and at least 4 weeks apart if given at age 13 years or older) **OR documented date of Chicken Pox disease** ___/___/_____

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

Please write in YES or NO to the following questions:

SECTION A: PAST DIAGNOSIS OF TUBERCULOSIS (TB)

1. Has patient ever been sick with tuberculosis? _____
2. Has patient ever had a positive PPD or Mantoux test? _____

SECTION B: TUBERCULOSIS (TB) EXPOSURE RISK QUESTIONNAIRE

1. Has patient previously been in a health-related academic program/major? _____
2. Was patient born in, or ever lived, worked or traveled for **more than one** month in any of the following:
   Africa, Asia, South America, Central America or Eastern Europe? _____
   Is patient HIV positive or chronically immunocompromised? _____
3. Do any of the following conditions or situations apply to the patient?
   a) Does patient have a persistent cough, fever, night sweats, fatigue, loss of appetite, or weight loss? _____
   b) Has patient ever lived with or been in close contact to a person known/suspected of having TB? _____

If **YES** to any of the above, **PPD IS REQUIRED.**
PPD test (skin test within the past 3 months): Placement Date___/___/___ Date Read ___/___/___
(Circle one) Negative Positive If positive, _____mm

If PPD is **POSITIVE**, **CHEST X-RAY** and **COPY OF REPORT IS REQUIRED**.

Revised May 2020