RANDOLPH COLLEGE

General Student Information

_____
Student's Name

_____
Date of Birth Social Security Number

_____
Street Address City State Zip

_____
Phone Number

_____ _____
Gender Sport if any

_____
Student email address

_____ _____
Name of Emergency Contact Relationship

_____
Emergency Contact Phone Number

Randolph College Health Center

revised
August 2025

2500 RIVERMONT AVE. • LYNCHBURG, VA, 24503 • (434) 947.8000

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Medical Record Forms

Attention Incoming Full-Time Students: Important Notice Regarding Medical Record Forms Submission

As you prepare to embark on your journey at Randolph College, it is essential to complete and submit all required medical record forms by the specified **deadline** of **July 15** for Fall semester admitted students, and **January 1** for Spring semester admitted students. This step is crucial for ensuring your healthy transition to campus life.

Why is the Deadline Important?

Review for Accuracy and Completion: Submitting your forms by the deadline allows our health and/or athletics administrative staff time to thoroughly review your documentation. This process is in place to ensure that all health-related requirements are met, safeguarding your well-being and that of the campus community.
Prerequisite for Campus Activities: Completion and timely submission of your medical record forms, including any required lab tests and immunizations, are **mandatory** before moving into your residential space, beginning classes, and/or participating in athletic practices/competitions. These forms are a critical part of your enrollment process.

Consequences of Late or Incomplete Forms Submission:

Inability to Move into Residential Space: Students who do not meet the submission deadline may face significant delays or be unable to move into their designated residential spaces.
Delay in Beginning Classes: Starting your classes on time is contingent upon the timely submission of your medical record forms. Late submissions could hinder your academic progress from the outset.
Exclusion from Athletic Participation: For student-athletes, participation in practices and competitions is directly linked to the completion of medical record forms, including any required lab tests. *Missing the deadline will exclude you from practices and games until your forms are completed, submitted, and reviewed.*

Action Required: Please ensure that you carefully review and complete all sections of the medical record forms and submit them before the deadline. We understand that some insurance companies cover the cost of physicals once every 365 days; however, *the stated deadline is firm*, and you may be responsible for payment to your healthcare provider for completing the physical exam and immunization documentation. We strongly encourage you to check with your insurance company about their claims and reimbursement policies.

Forms received after the deadline will be reviewed as time allows, but due to staff involvement in training and orientation sessions, that time is extremely limited. Information requiring a healthcare provider's completion and/or signature must be completed on the forms provided. Immunizations must be complete and up to date before submission of your forms. Please pay close attention to the dates required for immunizations [e.g., Tetanus booster (Td or Tdap) date must be within the last 10 years; meningitis immunization (MCV4) must be given on or after the age of sixteen, etc.] - schedule any missing/needed immunizations asap. *Make an appointment with your healthcare provider as soon as possible to prevent delays in form submission.*

Let's Work Together: Your adherence to this deadline is vital for a smooth start to your college experience. We are here to support you through this process and look forward to welcoming you to Randolph College.

The information supplied below by you and your provider may be used by health center staff and athletic training staff (for student-athletes only) to provide informed medical care and/or make referrals to other offices, both on- or off-campus, while you are enrolled at Randolph College. Any information provided will not otherwise be released without your written consent.

If you have questions regarding your medical record forms and/or submission of forms, please email kwertz@randolphcollege.edu

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Permission for Treatment

The College's student health center and athletic training staff (student-athletes only) have my permission to perform or authorize routine medical care and/or make referrals to area specialists or locations of medical services which are not provided at Randolph College. Under certain circumstances, I understand that I may require transportation 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) at the time of form completion, this form must *also* be signed by the parent or legal guardian so that appropriate diagnosis and treatment may be promptly conducted. 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: _____

Parent/Guardian Signature (if student is less than 18 years old): _____Date: _____

Health Insurance

Health Insurance is required for all full-time students attending Randolph College. Students must complete the online waiver process which provides 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 1 for Fall semester new and returning students and January 1 for Spring semester new and re-admitted students. Please note that state government-sponsored health insurance plans (Medicaid, for example) do not cover costs of routine medical care outside the student's state of residency. For *question*s related to health insurance, please click the *Contact Info* tab at the top of the College's insurance website. https://rcmdstudentbenefits.com/randolph/

Online Waiver form: https://rcmdstudentbenefits.com/randolph/ (please copy address into a web browser)

Please complete the insurance policy information below. You may also be required to upload copies of the front and back of your insurance card into the insurance website if you waive the College plan. Student-athletes will *also* need to upload their insurance card into the SportsWareOnLine www.swol123.net (please copy address into a web browser).

* Tricare policyholders must provide the name and date of birth of the enlisted family member as well as the student/covered member.

Policyholder's name:		Policyholders birthday:	
Policyholder's address: No./Street:	City:	State:	Zip:
Insurance company:	Policy #:	Group #:	
Insurance company address: No./Street:	City:	State:	Zip:
Insurance company phone:	Type of insurance: HMO ☐ PPO ☐ Other:		

Medications *(include prescription and non-prescription medications)*

Medication name:	Reason/use:	Dosage:	Frequency:
Medication name:	Reason/use:	Dosage:	Frequency:
Medication name:	Reason/use:	Dosage:	Frequency:
Medication name:	Reason/use:	Dosage:	Frequency:

Student-athletes are required to provide athletic training staff with extra rescue inhalers, EpiPens, medications for hypoglycemia/diabetes, or any other life-saving medications.

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If additional medications need to be listed, please add that information here or you may upload a complete list with your physical and immunization documentation.

Allergies and/or sensitivities *(include reactions beside each allergen)*

☐ ***NO KNOWN ALLERGIES***

Medication allergies/sensitivities:

Food allergies/sensitivities:

Sting or bite allergies/sensitivities:

Other allergies/sensitivities:

Current and Past Personal Medical History

Please check all that apply and give a brief explanation, including dates, in the space provided.

Condition	Date of occurrence/diagnosis	Brief explanation
Absent Organ (Is this congenital, or due to illness/injury?)		
Allergies		
Anemia		
Anxiety		
Arthritis		
Auto-immune disease		
Bone/joint injury or disease		
Cancer		
Chest Pain		
Chicken Pox		
Chronic Cough		
Concussion/TBI (include each occurrence and if you experienced loss of consciousness)		
Depression		
Diabetes		
Dizziness (vertigo)		
Eating Disorder(s)		
Environmental allergies/hay fever		
Epilepsy/seizure disorder		
Hepatitis		
Hernia		
Gastrointestinal		
Gynecological		

Hearing loss (Do you wear hearing aids?)		
Heart murmur/disease		
Hepatitis		
Hernia		
High/low blood pressure		
Hospitalization(s) for medical and/or mental health conditions		
Irritable Bowel Syndrome		
Jaundice/Liver Disease		
Kidney Disease		
Latex sensitivity		
Loss of anatomical body part (limb, eye, etc.)		
Lung disease (asthma, COPD, etc.)		
Malaria		
Marfan Syndrome		
Mental health diagnosis(es) other than depression or anxiety (Are you currently or have you ever been under the care of a mental health provider psychiatrist/ psychologist/licensed professional counselor? Do you take medications for any mental health conditions?)		
Measles		
Migraines/chronic headaches		
Mono (mononucleosis)		
Mumps		
Pneumonia		
Rheumatic Fever		
Sickle Cell Disease		
Skin/dermatological conditions (rashes, hives, etc.)		
STIs/STDs		
Stomach Ulcer		
Substance use disorders		
Surgeries (include all surgeries and dates)		
Syncopal episodes (fainting/passing out/sudden loss of consciousness)		
Tobacco use (include type and duration of use)		
Tuberculosis		
Vision changes/loss (Do you wear glasses or contacts?)		

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Access Requirements

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 give specifics in the appropriate box.

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

Vision	Hearing	Speech	Motor	Anatomical loss (please specify):

I hereby state to the best of my knowledge that all information I have provided is accurate. I have not withheld any information that could be considered relevant to my health and safety or to the health and safety of others. I will report any changes in my health condition to health center staff and athletic training staff (if applicable) in a timely manner.

Student Signature: _____Date: _____

Parent/Guardian Signature (if student is less than 18 years old): _____Date: _____

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Medical History	
If you answer "yes" to any of the following questions, please identify the question number along with dates and a brief explanation in the space provided below.	
1.	Have you had a medical illness in the past 12 months? *Yes* ☐ *No* ☐
2.	Have you ever undergone surgery for a medical condition or injury? *Yes* ☐ *No* ☐
3.	Have you ever suffered a head injury or concussion? How many? When? Did you lose consciousness? *Yes* ☐ *No* ☐
4.	Have you experienced memory or concentration problems due to a head injury or concussion? *Yes* ☐ *No* ☐
5.	Have you experienced memory or concentration problems due to a head injury or concussion? *Yes* ☐ *No* ☐
6.	Has any of your family members died of heart related problems before the age of 50? *Yes* ☐ *No* ☐
7.	Do you ever experience shortness of breath during or after exercise? *Yes* ☐ *No* ☐
8.	Have you experienced chest pain with exercise in the past year? (Heart racing, shortness of breath, etc.) *Yes* ☐ *No* ☐
9.	In the past year, have you passed out with exercise? *Yes* ☐ *No* ☐
10.	Have you had an illness/injury during the past year that restricted your normal activity for more than 1 week? *Yes* ☐ *No* ☐
11.	Have you suffered any internal injuries? *Yes* ☐ *No* ☐
12.	Do you have an ongoing chronic illness/condition? (i.e. diabetes, asthma ADHD, etc.) *Yes* ☐ *No* ☐
13.	Within the last year, have you been seriously injured while participating in athletics? *Yes* ☐ *No* ☐
14.	Have you ever had a sprain, strain, or swelling after injury? *Yes* ☐ *No* ☐
15.	Have you received an X-ray, MRI, or bone scan within the last 12 months? *Yes* ☐ *No* ☐
16.	Have you ever dislocated any joints or fractured any bones? *Yes* ☐ *No* ☐
17.	Have you ever been hospitalized overnight? *Yes* ☐ *No* ☐
18.	Have you experienced a seizure, fainting spell, or heat illness? *Yes* ☐ *No* ☐
19.	Are you currently taking any performance/ muscle enhancing supplements? (i.e. creatine, whey, etc.) *Yes* ☐ *No* ☐
20.	Have you suffered any ear, nose, or throat injuries? *Yes* ☐ *No* ☐
21.	Do you have a skin condition? *Yes* ☐ *No* ☐
22.	Have you ever passed blood in your urine? *Yes* ☐ *No* ☐
23.	Do you have dentures, partial plates, bridges, caps, or crowns? *Yes* ☐ *No* ☐
24.	Do you wear glasses or contacts while participating in athletics? *Yes* ☐ *No* ☐
25.	Do you feel the need to gain or lose weight? *Yes* ☐ *No* ☐
26.	Has your weight changed +/- 10 pounds the last 12 months? *Yes* ☐ *No* ☐
27.	Do you experience frequent headaches? *Yes* ☐ *No* ☐
28.	Have you ever been advised by a healthcare professional to NOT participate in athletics? *Yes* ☐ *No* ☐
29.	Have you NOT been allowed to participate in athletics due to an injury or medical condition? *Yes* ☐ *No* ☐
30.	Do you know of any injury health reason why you should NOT participate in Randolph College Athletics? *Yes* ☐ *No* ☐
31.	Do you know of any illness health reason why you should NOT participate in Randolph College Athletics? *Yes* ☐ *No* ☐
32.	Do the Randolph Athletic Trainers need notification of any other health related issue? *Yes* ☐ *No* ☐
33.	FEMALES ONLY: Do you experience irregular menstrual periods? *Yes* ☐ *No* ☐

Please state the question number first before explaining why you answered yes.

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Randolph College Student Authorization and Consent for Disclosure of Protected Health Information

I, _____, hereby authorize the Randolph College Student Health Center and/or Athletic Training Staff to disclose my protected health information in the event of sudden specific illness, injury, or other emergent health situation. This may include appropriate staff, medical providers, or athletic training staff of opposing teams. I understand that other health issues and injuries will be disclosed only with my written permission to the specified individuals named and within a specified time for expiration.

This consent expires 545 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the Student Health Center and/or Head Athletic Trainer of Randolph College. I understand that a revocation is not effective for any action that has already been taken in reliance on this consent.

Printed student name: _____ Student signature: _____ Date: _____

Printed parent/guardian name: _____ Parent/guardian signature: _____ Date: _____
(required if student is under the age of 18)

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Randolph College Physical

Please print this form to take to your healthcare provider for completion.

Student's full **legal** name (Last, First Middle): _____

Student's preferred name: _____ Preferred pronouns: _____

Gender: _____ Sex assigned at birth: _____ Student's date of birth: ___/_____

TO THE EXAMINING PROVIDER: Please complete the physical form and comment on all positive answers. The information supplied will be used only as a background for providing professional healthcare by student health services and/or athletic training staff. This information will not be released without prior written consent of the student.

T _____ P _____ B/P _____

Height (inches) _____ Weight (lb.) _____

Body Mass Index _____

Corrected Vision:

Right 20/_____ Left 20/_____

IF MEDICALLY INDICATED

Urinalysis:

Glucose _____ Protein_____ _____

Other_____ Micro_____

Hgb/Hct: _____/_____

Are there any abnormalities of the following systems? If yes, describe under the COMMENTS column.

SYSTEM	NORMAL	COMMENTS
General		
Head, eyes, ears, throat, dentition		
Cardiovascular		
Respiratory		
Genitourinary/pelvic exam *(if performed)*		
Gastrointestinal/abdominal		
Musculoskeletal		
Neck/cervical spine		
Arm/elbow/wrist/hand		
Back/shoulder		
Knee/hip/ankle/foot		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		
Other		

Has the student ever had any treatment or counseling for an emotional, behavioral, or psychological condition that would affect their ability to enroll in college or participate in athletics? (including eating disorders and/or substance abuse) ☐ No ☐ Yes*
(Explain):_____

*If yes, a full medical report from a physician, psychiatrist, certified therapist, or counselor is requested. A full report will include a statement of the diagnosis, treatment, response to treatment, and need for follow-up. This report should be directed to the Director of Student Health Services. This report will not be released without prior written consent of the student.

I have reviewed the data above and make the following recommendations for the student's participation in campus activities/physical education classes/athletics.

☐ CLEARED WITHOUT RESTRICTIONS
☐ Cleared AFTER further evaluation or treatment for _____
☐ Cleared for LIMITED PARTICIPATION (check and explain for all that apply):
  ☐ Not cleared for (specific sports): _____
  ☐ Cleared only for (specific sports): _____
☐ NOT CLEARED FOR PARTICIPATION (explain)_____
☐ Other (explain) _____

Provider Signature: _____ Date: _____

Provider Name and Address (printed): _____
_____

Provider Phone: (_____)_____ Fax: (_____)_____

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Randolph College Immunization Form

Please print this form to take to your healthcare provider for completion.

All information must be in English and in the MM/DD/YYYY format.

Student's name: _____ Student's date of birth: _____

Required Immunizations

The following immunizations are **required before arrival on campus** (you will not be able to move into your residential space or attend classes until completed).

DIPHTHERIA/TETANUS/PERTUSSIS (DTaP): Primary childhood series completed: _____

HEPATITIS B VACCINE: Dose #1: _____ Dose #2: _____ Dose #3: _____

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

MENINGOCOCCAL A, C, W, Y (MCV-4) VACCINE*: Dose #1: _____ Dose #2:_____
*Second dose must be given on or after the age of 16; if first dose given on or after age 16, only one dose required

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

TETANUS/DIPHTHERIA BOOSTER (Td/Tdap) *: Most recent dose: _____
*Must be within the last 10 years

VARICELLA VACCINE*: Dose #1: _____ Dose #2: _____
*Two doses 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: _____

Recommended Immunizations:

Hepatitis A: Dose #1: _____ Dose #2: _____

HPV: Dose #1: _____ Dose #2: _____ Dose #3 (if necessary): _____

Influenza: Last dose received: _____

Meningococcal B: Dose #1: _____ Dose #2: _____

Provider Signature_____ Date_____

Provider Name and Address (printed)_____
_____

Provider Phone (_____)_____ Fax (_____)_____

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Tuberculosis Screening

Please print this form to take to your healthcare provider for completion.

PPD is strongly recommended; however, CDC guidelines allow the following screening alternative. Please **circle** YES or NO to the following questions:

SECTION A: PAST DIAGNOSIS OF TUBERCULOSIS (TB)

Has student ever been sick with tuberculosis?	YES NO
Has student ever had a positive tuberculosis test? (PPD)	YES NO

SECTION B: TUBERCULOSIS (TB) EXPOSURE RISK QUESTIONNAIRE

Has student been in a health-related academic program/major?	YES NO
Was student born in, or have they lived/worked/traveled in (for more than one month) any of the following international locations? (please enter details if YES): Africa_____ Asia_____ Central America_____ Eastern Europe_____ Details: Did student receive BCG vaccine as an infant? (attach documentation):	YES NO YES NO
Is student HIV positive or chronically immunocompromised?	YES NO
Does the student have a persistent cough, fever, night sweats, fatigue, loss of appetite, or weight loss?	YES NO
Has student ever lived with or been in close contact to a person known or suspected of having TB?	YES NO

If YES to any of the above, Tuberculosis test (PPD) is REQUIRED

Placement Date_____/_____/_____ Assessment/Reading Date ____/_____/_____

Result _____mm Negative Positive (circle one)

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

Student Name_____ Date_____

Screening Form/Test Results Reviewed by_____ Date_____