

RANDOLPH COLLEGE MEDICAL RECORD

Demographics and Medical History - Pages 1 & 2/Physician Physical - Page 3/Immunization Form - Page 4

Required for ALL FULL-TIME incoming students

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

This record must be **completed and mailed 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)

Last Name (please print)	First Name	Middle Name	Social Security Number
--------------------------	------------	-------------	------------------------

Birth Date	Gender
------------	--------

Home Address (number and street)	City or Town	State	Zip Code
----------------------------------	--------------	-------	----------

Country	Cell Phone Number
---------	-------------------

Person to notify in case of an emergency	Relationship	Address
--	--------------	---------

Phone (in case of emergency): 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 must complete the online waiver providing proof of health insurance or enroll in the College 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, 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
---	--------------	------

RANDOLPH COLLEGE PHYSICIAN PHYSICAL

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 _____ Pulse _____ Blood Pressure _____

Urinalysis (if medically indicated): Sugar: _____ Hgb/Hct (if medically indicated): _____ Height _____ Weight _____
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.

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

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

Name _____ Year of Entry _____ Date of Birth _____

REQUIRED 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 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)

- | | | |
|---|-----|----|
| 1. Has patient ever been sick with tuberculosis? | YES | NO |
| 2. Has patient ever had a positive PPD or Mantoux test? | YES | NO |

SECTION B: TUBERCULOSIS (TB) EXPOSURE RISK QUESTIONNAIRE

- | | | |
|--|-----|----|
| 1. Has patient previously been in a health-related academic program/major? | YES | NO |
| 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? | YES | NO |
| Is patient HIV positive or chronically immunocompromised? | YES | NO |
| 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? | YES | NO |
| b) Has patient ever lived with or been in close contact to a person known/suspected of having TB? | YES | NO |

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

PPD (Mantoux) (within the past 12 months) Placement Date ____/____/____ Date Read ____/____/____
(Circle one) Negative Positive If positive, _____mm

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

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 24503-1526

Phone: 434-947-8130

Fax: 434-947-8106