

Randolph-Macon Academy

200 Academy Drive ♦ Front Royal, Virginia 22630

SINCE 1892

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Welcome! The goal of the nursing staff at Randolph-Macon Academy is to keep your student well. Please read over this **IMPORTANT** medical packet and complete all forms prior to registration day. **STUDENTS WITHOUT THE COMPLETED MEDICAL PACKET WILL NOT BE PERMITTED TO STAY AT R-MA.**

1) Physical

ALL students **MUST** have a physical each academic school year. (This includes **NEW**, **RETURNING** and **INTERNATIONAL** students). Your physician must sign the Health Evaluation form each year. Please see below for date requirements.

Academic Term	Physical must be completed after:
2010 Summer Session	August 1, 2009
2010 Summer Session & Academic Year 2010-11	June 1, 2010
Academic Year 2010-11	June 1, 2010

2) Immunization Records

Immunizations may be documented on the physical form or photocopied and attached with health forms. They must be current.

3) Proof of Medical Insurance

A copy of the student's medical insurance card (front and back) must be provided. International students must obtain medical insurance through our school.

4) Emergency Medical Release Form (EMR)

The EMR form allows R-MA to seek medical or surgical attention for your child. This release covers both on and off-campus events sponsored by the Academy.

5) HIPAA Form

This form authorizes the R-MA Nursing Department to use and disclose your student's individual health information on a need-to-know basis. This allows for the best care to be given to your student by necessary staff members at R-MA or any physician or hospital.

If you have any questions, please do not hesitate to contact the nurses at 540-636-5210 or nurses@rma.edu.

Susan Carden, RN
Director of Nursing

Cindy Bohm, RN
School Nurse

Tara Housden, LPN
School Nurse

Randolph-Macon Academy



Health Evaluation

To the examining physician: Please review the student's history and complete this form. Please comment on all "yes" answers. This information will be used as a background for providing the necessary health care while the student is at Randolph-Macon Academy. **ALL INFORMATION MUST BE COMPLETELY FILLED IN.**

Student's Name _____ Date of Birth _____ / _____ / _____ Sex _____ M _____ F

	Immunization Record	1	2	3	4	5
Height	DTP (minimum 3 doses required- DT within last 10 years)					
Weight	Polio (minimum 3 doses required)					
Blood Pressure	MMR (2 doses required)					
	Hepatitis B series (required) if pediatric 2-dose series, please note					
	Tuberculin Skin Test (required) (must be within 2 years)	Date	Type	Result _____ mm		
	Meningococcal Vaccine (Optional)					
	Tetanus/ Tdap booster shot (must be within 5 years) (required for all incoming 6 th graders)					

Are there abnormalities in the following areas? Describe fully. Use additional sheet if needed.

	Yes	No	Comments		Yes	No	Comments
Head, ears, nose, throat				Genitourinary			
Hearing				Musculoskeletal			
Respiratory				Metabolic/endocrine			
Cardiovascular				Neuropsychiatric			
Gastrointestinal				Skin			
Abdomen				Any other condition			
Eyes							

Any known condition or injury of:	Date	Treatment	Restrictions
Ankle			
Knee			
Shoulder			
Head (including loss of consciousness)			
Other injury			

Is this student capable of physical activity and participation in a competitive athletic/military program? Yes ___ No ___

TO ALL STUDENTS, PARENTS, PHYSICIANS: PLEASE BE CANDID IN YOUR ANSWERS ON THIS FORM. This is a **CONFIDENTIAL** document for the use of the professional staff at the Academy. This side is to be filled out by the parent or guardian and reviewed by your physician.

PERSONAL HISTORY: All questions must be answered. Comment on all “YES” answers in the space below or on an additional sheet. Indicate if you have or have ever had any of the following:

	Yes	No		Yes	No		Yes	No
Measles			Seizures			Ear, nose, throat trouble		
German measles			Disease/injury of joints			Eye trouble-Rx needed for glasses/contacts		
Mumps			Back problems			Gum/tooth trouble		
Chicken pox			“Trick” knee, shoulder			Stomach/intestinal trouble		
Malaria			High/low blood pressure			Gallbladder trouble		
Tuberculosis			Pain/pressure in chest			Jaundice		
Amoebic dysentery			Heart palpitations			Recurrent diarrhea		
Rheumatic fever			Chronic cough			Frequent urination		
Venereal disease			Shortness of breath			Diabetes		
Tumor, cancer, cyst			Hay fever			Albumin/sugar in urine		
Hernia			Asthma (last attack)			Kidney disease		
Weakness/paralysis			Recurrent colds			Bedwetting		
Dizziness/fainting			Sinusitis			Recurrent headaches		

PRESCRIPTION MEDICATIONS	DOSE	FREQUENCY
NOTE: R-MA requires medications to be in original Rx bottles with directions in English.		

Glasses/contact prescription information

Student does not wear glasses/contacts

Please list ALL allergies:

Examining physician (please print) _____ Signature _____

Date _____ Phone # (____) _____ Fax # (____) _____

Address _____

Parent Signature _____ Date _____

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Emergency Medical Release Form



This form must be completed and signed by a parent or guardian in order for your child to register.

STUDENT'S NAME _____ DOB ____/____/____ M ____ F ____
Last First Middle

HOME ADDRESS _____
Number and Street City State Zip

SOCIAL SECURITY # _____ - _____ - _____ SCHOOL YEAR _____ GRADE _____

Student resides with (please circle one): Both Parents, Mother, Father, Guardian, Other _____

Father's full name _____ DOB ____/____/____ Res. Phone (____) _____

Email address _____ Cell Phone _____ Bus. Phone (____) _____

Mother's full name _____ DOB ____/____/____ Res. Phone (____) _____

Email address _____ Cell Phone _____ Bus. Phone (____) _____

Guardian's full name _____ DOB ____/____/____ Res. Phone (____) _____

Email address _____ Cell Phone _____ Bus. Phone (____) _____

Alternative responsible person to be reached in case of emergency if parent or guardian is unavailable:

Name _____ Relationship _____ Phone (____) _____

STUDENT'S HEALTH INSURANCE: (Health Insurance is required and a copy of the insurance card, front and back, must be included with this Health Form.)

Insurance Company _____

Policy holder _____

Group # _____

Subscriber # _____

Insurance Company Phone (____) _____

Prescription Coverage (circle one): yes / no

Please list ALL allergies:

MEDICAL AUTHORIZATION:

I hereby authorize any hospital or physician to provide necessary medical care to the student named above. This authorization does not include medical care beyond what is usual and customary for treatment on an outpatient basis, but does include x-rays, blood work, urinalysis and appropriate medications.

- In an emergency, if I cannot be reached by R-MA or hospital staff or by a treating physician, I consent for R-MA to act in loco parentis and to grant permission for emergency treatment, including surgery requiring the use of anesthetics.
- I authorize the R-MA infirmary staff and/or designated R-MA personnel to provide minor first aid and dispense routine medication specific to the needs of the above-named student.
- I authorize the R-MA infirmary staff to exchange medical information with health-care providers as necessary to ensure appropriate medical care for my child.
- I authorize the R-MA infirmary staff to inform R-MA faculty and staff members about my child's medical conditions or treatment that may bear on his/her participation and performance in R-MA's educational, and/or extracurricular activities.

Parent's Signature _____ Date _____

Print Name _____

Randolph-Macon Academy



HIPAA Notice of Privacy Practices

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION

Each time your child visits our infirmary, a hospital, physician, or other health care provider, a record of his/her visit is made. Typically this record contains your child's symptoms, examination and test results, diagnosis, treatment, and a plan for future care. This information is referred to as the medical record and it serves as:

- 1) A basis for planning care
- 2) A means of communication among the health professionals
- 3) A legal document describing the care received
- 4) A means by which you and a third-party payer can verify that services were rendered
- 5) Source of information for public health officials
- 6) A tool for improving the care we deliver

YOUR HEALTH INFORMATION RIGHTS

Although your child's health record is the physical property of the medical department of this facility, the information belongs to you. You have the right to:

- 1) Request a restriction on certain uses and disclosures
- 2) Inspect or obtain a paper copy of the information upon request, for which there may be a copying fee
- 3) Amend the record
- 4) Obtain an accounting of disclosures
- 5) Request communications of information by alternative means
- 6) Revoke your authorization to use/disclose your child's health information except to the extent that action has already been taken

OUR RESPONSIBILITIES

R-MA is required to:

- 1) Maintain the privacy of your child's health information
- 2) Provide you with a notice as to our legal duties and privacy practices
- 3) Abide by the terms of this notice
- 4) Accommodate reasonable requests to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and make the new provisions effective for all protected health information we maintain. We will not use or disclose your child's health information without your authorization except as described above.

FOR MORE INFORMATION

If you have questions, you may contact the R-MA Infirmary at 540-636-5210. If you believe your child's privacy rights have been violated, you have the right to file a written complaint with the Director of Nursing at Randolph-Macon Academy, 200 Academy Drive, Front Royal, Virginia 22630.

I acknowledge that I have received a copy of this notice of privacy practices and consent for my child's name, address, phone number, social security number, insurance information, and other pertinent health information to be given to any other healthcare providers caring for my child which also includes: pharmaceutical care, dental care and physical and occupational therapy services.

Parent/Guardian's Signature _____ Date _____

Student's Signature _____ Date _____