

Comprehensive Student Health and Disability Report

Form 1 of 4

Lewis & Clark College
0615 S.W. Palatine Hill Road
Portland, Oregon 97219-7899

Student Health Service
503-768-7165
503-768-7167 fax
health@lclark.edu

General Information

All entering students are required to complete this Comprehensive Student Health and Disability Report prior to attendance. All information disclosed on this form will be kept confidential and will be shared with appropriate college personnel on a need-to-know basis only. Please return your completed form to the Student Health Service using the enclosed envelope.

Student Information

Date _____

Name last _____ first _____ m.i. _____ Sex M F T

Address street _____ city _____ state _____ zip _____

Phone _____ E-mail _____

Social Security number Marital status _____ Number of children _____

Date of birth M D Y Place of birth city _____ state _____ country _____

Parent/Guardian Consent *Required only if student will be under 18 years old at time of enrollment.*

With the understanding that every effort will be made to contact me in case of medical emergency, I hereby give my permission to the health care provider selected by the College to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for my daughter/son submitting this medical report.

Parent/guardian signature _____ Date _____

Printed name of parent/guardian _____ Phone _____

Address street _____ city _____ state _____ zip _____

Emergency Contacts

Primary Name _____ Relationship _____

Address street _____ city _____ state _____ zip _____

Phone home _____ office _____ cell _____ E-mail _____

Secondary Name _____ Relationship _____

Address street _____ city _____ state _____ zip _____

Phone home _____ office _____ cell _____ E-mail _____

Family History

Are you adopted? yes no

| name | occupation | year of birth | state of health | age at death | cause of death |
|------------|------------|---------------|-----------------|--------------|----------------|
| Father | | | | | |
| Stepfather | | | | | |
| Mother | | | | | |
| Stepmother | | | | | |
| Sibling | | | | | |
| Sibling | | | | | |

Please circle any of the following that have been experienced by close relatives: high blood pressure, heart disease, stroke, bleeding disorder, diabetes, ulcers, kidney disease, epilepsy, migraine, arthritis, cancer, tuberculosis, asthma, allergies, mental illness

This page left blank intentionally.

Health History *This page must be completed by the student.*

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only.

1. Describe any ongoing health problems or conditions requiring medical care.

Have you ever had any of the following?

- | | Yes | No |
|--|--------------------------|--------------------------|
| 2. Operation or serious injury | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hospitalization | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Mumps | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Mononucleosis (Mono) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. German measles (Rubella) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Hard measles (Rubeola) | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Chicken pox | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. BCG vaccine (T.B. vaccine) | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Adverse or allergic reaction to any medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Allergic reaction to food, insect bites, or other stimulus not related to medication | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. X-ray therapy to the head or neck | <input type="checkbox"/> | <input type="checkbox"/> |

Details: Identify question by number; include diagnosis, age or dates, and treatment.

14. List any medications you use.

Have you ever had or been treated for any of the following?

- | | | |
|---|--------------------------|--------------------------|
| 15. Serious disease of eyes, ears, nose, or throat | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Frequent or severe headaches or convulsions, or a severe head injury | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Lung disease, asthma, persistent cough, or shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. High blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding, or other intestinal problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Sugar, protein, or blood in urine, or bladder or kidney problem | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. A sexually transmitted disease (STD) | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Diabetes, thyroid, or other endocrine disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Anemia or other disorder of the blood | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Bone, joint, or muscle problem; back pain; arthritis; physical deformity; or paralysis | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Hay fever, asthma, hives, or other allergy | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Severe acne, eczema, or other skin disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Cancer or other tumor | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. A disorder not listed above (specify) | <input type="checkbox"/> | <input type="checkbox"/> |

Do you . . .

- | | | |
|---|--------------------------|--------------------------|
| 29. Know your blood type? Type: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Smoke or chew tobacco? Amount: _____ Years: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 31. Have a special diet? (explain) | <input type="checkbox"/> | <input type="checkbox"/> |
| 32. Drink alcoholic beverages? (specify type and number of drinks per week) | <input type="checkbox"/> | <input type="checkbox"/> |

Women Only

- | | | |
|--|--------------------------|--------------------------|
| 33. Have you ever had a menstrual disorder or disorder of the female organs or breasts? | <input type="checkbox"/> | <input type="checkbox"/> |
| 34. Have you had a pelvic exam and Pap smear? (specify date and findings of your most recent exam) | <input type="checkbox"/> | <input type="checkbox"/> |
| 35. Do you do a monthly breast self-exam? | <input type="checkbox"/> | <input type="checkbox"/> |
| 36. Do you take birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> |
| 37. Do you use any other form of contraception? (specify) | <input type="checkbox"/> | <input type="checkbox"/> |

Men Only

- | | | |
|--|--------------------------|--------------------------|
| 38. Have you ever had any disorder of the penis, testicles, or prostate? | <input type="checkbox"/> | <input type="checkbox"/> |
| 39. Do you do a monthly testicular self-exam? | <input type="checkbox"/> | <input type="checkbox"/> |

Signature of student _____

Date _____

Immunization Record

Students who do not complete this form will experience registration holds or cancellations.

Lewis & Clark College
0615 S.W. Palatine Hill Road
Portland, Oregon 97219-7899

Student Health Service
503-768-7165
503-768-7167 fax
health@lclark.edu

Student Information

Name last _____ first _____ m.i. _____ Date _____

Date of birth M D Y

Tuberculosis Control

The tuberculosis skin test is required and must be done within six months of admission. The test may be done at the Student Health Service on admission.

Type of test _____ Result (mm of induration) _____ M D Y

Chest x-ray (if tuberculosis test is positive) _____ Result _____ M D Y

Immunizations

MMR

1. M D Y

2. M D Y

Oregon law requires students to have two doses of MMR (measles, mumps, and rubella) vaccine administered at least 28 days apart and after the student is 12 months of age. If the student receives the first dose of measles vaccine fewer than 30 days before starting at Lewis & Clark, the student will have until the beginning of the second semester to obtain the second dose.

Students who have not complied with the MMR vaccination requirement and do not meet exemption criteria will experience registration holds or cancellations.

RECOMMENDED VACCINES

DPT (diphtheria/tetanus)

1. M D Y

2. M D Y

3. M D Y

4. M D Y

Booster M D Y

Polio

1. M D Y

2. M D Y

3. M D Y

4. M D Y

Booster M D Y

Varicella

1. M D Y

2. M D Y

Meningococcal

1. M D Y

Hepatitis B

1. M D Y

2. M D Y

3. M D Y

HPV

1. M D Y

2. M D Y

3. M D Y

OTHER VACCINES

Hepatitis A

1. M D Y

2. M D Y

Twinrix (Hepatitis A and B)

1. M D Y

2. M D Y

3. M D Y

Typhoid

1. M D Y

Yellow Fever

1. M D Y

I meet the following exemption(s) and thus do not need the MMR immunization:

- My MMR titer report is attached and indicates I am immune.
- A signed physician or nurse practitioner statement is attached indicating I had the diseases. (Statement must include date.)
- A signed physician or nurse practitioner statement is attached verifying I have a medical reason for not receiving the immunization (anaphylactic reactions to eggs, immunocompromised state, etc.).

Signature of health care provider _____ Date _____

I am an adherent to a religion the teachings of which are opposed to immunization, and so I request to be exempted from the MMR immunization requirement.

Signature of student _____ Date _____

Note: For complete information from the American College Health Association regarding vaccine recommendations, please view www.acha.org/info_resources/RIPiStatement.pdf

Comprehensive Student Health and Disability Report

Form 2 of 4

Lewis & Clark College
0615 S.W. Palatine Hill Road
Portland, Oregon 97219-7899

Student Health Service
503-768-7165
503-768-7167 fax
health@lclark.edu

Mental Health History

Students with a history of emotional or behavioral challenges are strongly encouraged, but not required, to complete the questions below. Our counseling staff will review this information and in some cases will contact the student prior to his or her arrival on campus to make a connection and suggest possible resources. All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to the Student Health Service using the enclosed return envelope.

Student Information

Name last _____ first _____ m.i. _____ Date _____

This page was completed by: student student and parent/guardian

1. Describe any medical or mental health problems or conditions that have required psychological care.

Have you had or experienced any of the following during the last four years?

| | Yes | No |
|---|--------------------------|--------------------------|
| 2. Depressive disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. An anxiety disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. An eating disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Bipolar disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Obsessive-compulsive disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. An anger management issue | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. PTSD | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. ADD/ADHD | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Suicidal ideation | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. A suicide attempt | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. A sleep disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Panic disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. A learning disability | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. An antisocial or conduct disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Alcohol or substance abuse or dependence | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. An act of self-mutilation (cutting, branding, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |

Details: Identify question by number; include diagnosis, age or dates, and treatment.

18. Are you now taking or have you ever taken medication for any of the above? Yes No

(specify medication and dates) _____

19. Do you intend to begin or continue psychotherapy during college? Yes No

20. Have you been hospitalized for a psychiatric disorder? Yes No

21. Have you been treated for alcohol and/or drug addiction? (specify dates) Yes No

Comprehensive Student Health and Disability Report

Form 3 of 4

Lewis & Clark College
0615 S.W. Palatine Hill Road
Portland, Oregon 97219-7899

Student Health Service
503-768-7165
503-768-7167 fax
health@lclark.edu

Disability Accommodations

All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to the Student Health Service, using the enclosed return envelope.

Student Support Services addresses the academic needs of students with documented physical, psychological, and learning disabilities. Accommodations may include, but are not limited to, note takers, tutors, sign language interpreters, taped text books, and enlargement of written materials.

Accommodations are available upon request to those students entitled to them under Section 504 of the Rehabilitation Act of 1973 and the Americans With Disabilities Act of 1990. Filling out this form does not automatically qualify you for accommodations. To receive services, a student must provide appropriate documentation of his or her disability. If your documentation is incomplete or inadequate for our purposes, you may be granted interim accommodations until more detailed or timely documentation can be arranged.

Learning disability and ADHD testing can be arranged at Lewis & Clark with independent test specialists. Lewis & Clark's health insurance provider generally will cover a significant portion of the cost of testing for any student who has purchased coverage.

All information concerning your disability status will be kept confidential according to federal guidelines. If you fill out and return this form you will receive a copy of the College's disability policy upon your arrival. This document outlines the rights and responsibilities of students with disabilities at the College.

You will need to request accommodations each semester by filling out a simple form in the Student Support Services office. This will enable us to help you make any arrangements necessary with the instructors of your upcoming classes.

If you have a disability, please complete the following questions so that we will have an idea of the services you may need. If you think you might need to request accommodations at any time while at the College, please also include a copy of any documentation you have (or send it to us separately at your earliest convenience). For more information, please check our website at www.lclark.edu/dept/access.

Student Information

Name last _____ first _____ m.i. _____ Date _____

1. What is the nature of your disability? _____

2. How and when was your disability diagnosed and documented? _____

3. What types of accommodations have you used? _____

4. Are there any new accommodations you anticipate requesting at Lewis & Clark? If so, please specify. _____

5. Do you give us your permission to release information concerning your disability to your advisor? _____

Comprehensive Student Health and Disability Report

Form 4 of 4

Lewis & Clark College
0615 S.W. Palatine Hill Road
Portland, Oregon 97219-7899

Student Health Service
503-768-7165
503-768-7167 fax
health@lclark.edu

General Wellness Information

Students are encouraged to answer the following questions. These answers will be used to develop health education programming, communication, and materials specific to the needs of students. All information disclosed on this form will be kept confidential and will be shared with appropriate College personnel on a need-to-know basis only. Please return your completed report to the Student Health Service, using the enclosed return envelope.

Student Information

Name last _____ first _____ m.i. _____ Date _____

Please indicate if you regularly engage in any of the following forms of exercise. Check all that apply.

- Running
- Walking
- Working out
- Swimming
- Hiking
- Skiing/snowboarding
- Yoga
- Rock climbing
- Biking (road/mountain)

Team sports (specify) _____

Other (specify) _____

What wellness-related subjects are you interested in or concerned about as you come to Lewis & Clark? Check all that apply.

- Stress
- Fitness and nutrition
- Spirituality
- Sexual health
- Sexuality
- Sexual assault
- Alcohol and other drugs
- Mental health and well-being
- Meditation

Other (specify) _____

How would you prefer to receive wellness information? Check all that apply.

- Leaflets/pamphlets/flyers
- Campus media
- Health Center staff
- Health educators
- Friends
- Resident assistants
- Peer educators
- Spiritual advisers
- Off-campus health professionals
- Faculty/staff
- Internet

Other (specify) _____

What plans do you have to maintain a healthy and balanced lifestyle while at Lewis & Clark?
