Welcome from all of us in health services!

This packet contains important information about the health care services we provide at Reed, information about a specific health concern, and some forms for you to fill out so that we have the information we need about you.

We look forward to having you at Reed. Please stop by to meet our staff, and be assured we’ll do our best to meet your needs. As you review this information, please let us know if you have any questions.

Michael Brody, PMHNP
Director of health and counseling

Mary Leineweber, RNC
Medical services manager

Medical Forms

The medical forms that you and your health care provider complete will become the basis of your health chart. This information will aid our health care professionals in managing any medical or psychological illnesses, problems, emergencies, or accidents you may experience while at Reed. If possible, please arrange to have a copy of your medical records sent to us before you arrive. Be sure to keep a copy of everything you send.

Please return the forms in the enclosed prepaid envelope by August 1, if possible. They must be returned before registration. The forms include:

1. Face sheet.

2. Immunization record. Please note the specifics on this form regarding measles immunization required by the State of Oregon and tuberculosis screening documentation.

3. Health assessment form. You will need to make an appointment for a physical exam with your health care provider and present this form to him or her for completion and signature. Please include any recommendations (including medical records) for ongoing medical needs you may have while at college.

4. Self-assessment form. We ask that you complete this form as accurately as possible to let us know of any ongoing health or counseling concerns you (or your health care provider) may have.

5. Lifestyle questionnaire. This form helps us understand your current health practices.

International Students and Immunizations

Specific information about immunizations for the diseases listed on the college immunization form is required. The American College Health Association, the Center for Disease Control, and the Reed College health center require evidence of immunization.

Tuberculosis (TB) screening

Students from low-incidence countries, as designated by the Oregon Department of Public Health, are not required to have TB screening.

Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from any country EXCEPT Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

If you were born outside the above countries, you are at higher risk of being infected with tuberculosis. Tuberculosis skin testing is required for those students born outside the low-incidence countries. Any student who has a history of a previous positive TB test should
not be retested; this student will need to have a chest x-ray. You will need to bring a copy of the x-ray report or physician documentation of treatment for TB. Please complete the TB Screening Documentation form found in this packet and return it in the envelope marked C.

How to locate immunization records

1. Family health records file
2. Immunization booklet record from childhood physician, in family’s possession
3. Baby book
4. Ask immunizing doctor for a copy of your shot record
5. Public health clinic. Please keep in mind that immunization records are maintained for a variable number of years, and often only by the medical provider or clinic that actually gave the vaccines to you.
6. High school or college record of immunization—easier for school personnel to locate before you graduate/transfer, but still usually possible to obtain afterward. It could be in academic transcripts or health folder.

Confidentiality issues and your medical records

The health services staff works to promote health and wellness in our community, and we are governed by the legal and ethical guidelines of our professions. Your health record will be kept in a locked file in the health services office and will not become part of your college record. Our goal is to provide the best health care possible in order to support your well being, and your successful academic performance at Reed College.

None of the information will be shared without your consent, except in the case of extreme emergencies, and only if necessary for your welfare. In all other cases, your permission will be obtained before releasing any information.

Health care services and charges

Our primary health care and mental health services are available to all Reed students regardless of insurance provider. The cost of student health and counseling services is paid through student fees. There are additional charges for lab work, x-rays, and prescriptions. When evaluation and treatment needs exceed our primary medical resources, or if after-hours urgent or emergency care is needed, a student will be referred to an outside provider, who will then bill the student for services.

Insurance coverage

All international students are required to submit evidence of international health insurance coverage or to purchase international health insurance through the college.

Please look closely at the enclosed description of the international college health plan. Student insurance coverage becomes especially important when a student has health care needs that exceed the scope of service provided by the college health service, or when a student chooses to receive care off campus. For those students covered by the college plan, Reed’s health services acts as the point of pre-authorization, thereby facilitating and expediting referrals in the Portland metropolitan area.

You will be billed through the business office for the college plan unless you return the insurance waiver form, which will be found in this “Getting Started at Reed” packet. If you choose, return the form in the envelope addressed to Student Services.

The cost of the college insurance plan is $294 per semester, and $588 for the entire school year. Fall semester covers August 18, 2006 through January 13, 2007. Spring semester covers January 14, 2007 through August 16, 2007. Coverage during the summer may be restricted depending on several factors. For more information, call Sara Rosenberger or Janet McConnell in the business office at 503/777-7504, or email studentac-

Counts@reed.edu.

Meningitis information

The college wants you to be well informed about meningitis.

What is meningitis?

Meningitis is an inflammation of brain and spinal cord membranes caused by either viruses or bacteria. Bacterial (meningococcal) meningitis, the more serious—but fortunately, less common—form of the disease, occupies the current focus of our attention. Meningococcal meningitis progresses very rapidly and therefore requires early diagnosis and aggressive treatment with antibiotics.

The disease strikes one per 100,000 for both the general population and students living off campus. The risk increases to three per 100,000 students living in on-campus housing.

Symptoms

Symptoms often mimic those of the flu, including high fever, severe headache, stiff neck, nausea, and lethargy. In advanced cases a diffuse purple rash may develop. If you experience any of these symptoms or have potentially been exposed to someone diagnosed with meningitis, immediately report to the health center or, during off hours, go to the emergency room of a local hospital. Approximately 10 percent of those who contract the disease die; many others suffer permanent and debilitating damage to the brain, limbs, kidneys, or hearing. Early intervention is the best way to manage the severity of the symptoms.

Who is at risk?

The disease is spread through contact with an infected person’s oral secretions. Such contact includes sharing utensils or drinking glasses, kissing, and coughing. It also appears that smokers, those under physical stress, and IV-drug users may be at increased risk for contracting the infection.

Vaccination

A partially effective vaccine is available to students who request it at a cost of approximately $80. Most medical plans,
however, will not cover this kind of preventive treatment. Approximately 100 cases of meningitis are reported in Oregon each year; over half these cases are caused by a strain prevalent in the Pacific Northwest that is not covered by the vaccine. Although the college is not requiring widespread use of the vaccine at this time, in accordance with recent recommendations of the Advisory Committee on Immunization Practices (ACIP) and the American College Health Association (ACHA), the new conjugate vaccine (menactra) is recommended for populations at increased risk, including college freshmen living in dormitories or residence halls.

We encourage you to discuss this option with your family and your health care provider before coming to Reed.

If you have any other questions or concerns, please ask a member of the health center staff.
## FACE SHEET

<table>
<thead>
<tr>
<th>Last name (please print)</th>
<th>First</th>
<th>Middle</th>
<th>Social Security #</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home address</th>
</tr>
</thead>
<tbody>
<tr>
<td>City</td>
</tr>
<tr>
<td>Home phone</td>
</tr>
</tbody>
</table>

## FAMILY HISTORY

<table>
<thead>
<tr>
<th>occupation</th>
<th>age if living</th>
<th>presently in good health?</th>
<th>if deceased, age at death</th>
<th>cause of death</th>
</tr>
</thead>
</table>

**FATHER**

**MOTHER**

**SISTER(S)**

**BROTHER(S)**

## INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Policy holder</th>
<th>Policy holder social security #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer/carrier</td>
<td>Insurance company name</td>
</tr>
<tr>
<td>Insurance company address</td>
<td>Phone</td>
</tr>
<tr>
<td>Individual membership #</td>
<td>Group #</td>
</tr>
<tr>
<td>Type of coverage</td>
<td>Coverage to age</td>
</tr>
</tbody>
</table>

Please compare your insurance coverage with the plan offered through Reed College. You may find it beneficial to consider having both the college coverage, and your existing coverage as well.

## IN CASE OF EMERGENCY PLEASE CONTACT (please keep updated)

<table>
<thead>
<tr>
<th>Name of parent or guardian</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>phone (work)</td>
<td>phone (home)</td>
</tr>
</tbody>
</table>

Please list alternate person in case the above individual cannot be reached:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone (work)</td>
<td>phone (home)</td>
</tr>
</tbody>
</table>

In certain circumstances, it may become necessary for the health center to share information regarding your health status with other professionals, either to protect your health or that of others in the Reed community. Consent for disclosure may be withheld and may be cancelled in writing at any time. Reed College would appreciate your authorization for release, indicated by your signature below.

Signature | Date
IMMUNIZATION FORM

Immunization record for:

___________________________________________________

LAST NAME (PLEASE PRINT)  FIRST

__________________________________________________________________________

IF INFORMATION SUBMITTED BY A STUDENT REGARDING MEASLES VACCINATION IS INCOMPLETE, A HOLD WILL BE PLACED ON THE SECOND SEMESTER OF REGISTRATION AT REED.

Date of immunization  Date of booster

Measles (Rubeola)  ____________________________  ____________________________

Measles/mumps/rubella (MMR)*  ____________________________  ____________________________

*Each entering full-time student born on or after January 1, 1957, must have two doses of measles vaccine or MMR vaccine:

• Two doses (documented by month and year of each dose) on or after the first birthday, with a minimum of 30 days between the doses, OR

• No available documentation for the month and year of the first dose, but documentation of the month and year of the second dose on or after December 1989.

FOR EXEMPTION FROM MEASLES IMMUNIZATION, PLEASE READ BACK SIDE OF THIS FORM AND SIGN.

RECOMMENDED VACCINES:

Tetanus-Diptheria (within 10 years): date childhood series completed _____/_____/_____

  Date of most recent booster _____/_____/_____

Polio: date series completed (final dose given) _____/_____/_____

Hepatitis A: dose 1 _____/_____/_____   dose 2 _____/_____/_____  

Hepatitis B: dose 1 _____/_____/_____   dose 2 _____/_____/_____   dose 3 _____/_____/_____  

Varicella (chicken pox): dose 1 _____/_____/_____   dose 2 _____/_____/_____   OR, date of disease _____/_____/_____  

Meningococcal: dose 1 _____/_____/_____  

**Please see enclosed letter regarding meningitis vaccine

OTHER IMMUNIZATIONS RECEIVED:

__________________________________________________________________________  date _____/_____/_____

__________________________________________________________________________  date _____/_____/_____

__________________________________________________________________________  date _____/_____/_____

2006
Individuals with religious or medical exemption(s) (except a verified history of disease or blood test indicating immunity to Rubeola) are not protected against measles (Rubeola). This means that they are at risk for getting the disease. In the event of an outbreak, individuals with a religious or medical exemption(s) for measles may be excluded from the college, under the direction of the student health services director and/or the local health officer.

**AGE EXEMPTION** (Please indicate date of birth if born before 1957, and therefore considered immune):

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
</table>

**MEDICAL EXEMPTION** (Acceptable bases include):

- Serious allergic reactions (anaphylactic) to eggs, Neomycin, or other vaccines. Pregnancy or intent on becoming pregnant within three months.
- Immunosuppression such as occurs with cancers (leukemia, lymphoma) or medications for such diseases.
- Taking high doses of cortisone-type medications for more than two weeks.

All medical exemptions require a physician's signature to acceptably comply. Individuals with HIV-positive antibodies, or with leukemia in remission who have not received chemotherapy for at least three months, may receive the measles vaccine.

**CERTIFICATION:**
I certify that this individual should be exempted from the requirements for the measles (Rubeola) vaccine based on:

A. History of disease  Month and year ________________________________

B. Rubeola Immune titer  Result and date ________________________________

C. The following medical reason ____________________________________________  which constitutes a medical contraindication in accordance with the advisory committee on immunization practices of the U.S. Public Health Service for measles (Rubeola) vaccine (see above).

<table>
<thead>
<tr>
<th>PHYSICIAN’S SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICIAN’S NAME (PLEASE PRINT)</th>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDRESS</th>
<th>PHONE</th>
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<td></td>
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</tbody>
</table>

**RELIGIOUS EXEMPTION**
I have read and understand the above information. I am adherent to a religion, the teachings of which are opposed to immunization, and therefore request that I be exempted from the immunization requirement.

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>DATE</th>
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<tbody>
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</table>

If you have any questions regarding this requirement, call Reed College health services at 503/777-7281.
TUBERCULOSIS SCREENING DOCUMENTATION FORM

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH

COUNTRY

Tuberculosis screening is not required for students born in the United States or low-incidence countries, as designated by the Oregon State Health Division, which include:

Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

Students born outside the above countries, or students who have arrived within the past five years from countries where TB is endemic, are at higher risk of being infected with tuberculosis. A Tuberculosis skin test within the past six months is required for these students. Students who have a new positive TB skin test (PPD) must have a chest X-ray.

Any student who has had a documented positive TB test (PPD) in the past should not be retested. These students should have a chest x-ray (documented negative chest X-ray within a year at another facility may be used in lieu of repeat film at Reed). Please provide documentation of previous TB skin tests and a copy of the X-ray report within the past year.

TUBERCULIN SKIN TEST

Date given: ___________________________ Date read: ___________________________

mm induration: ___________________________

Have you ever taken INH for a positive TB skin test? [ ] Yes [ ] No date ___________________________

Have you ever had a BCG inoculation? [ ] Yes [ ] No if yes, when? date ___________________________

SIGNATURE OF HEALTH CARE PROVIDER

CHEST X-RAY

Required for those with a positive skin test, history of a positive skin test, or history of tuberculosis infection.

Date of x-ray: ___________________________ Results of reading: ___________________________

(must be within the past year)

SIGNATURE OF HEALTH CARE PROVIDER

The registrar and student services dean will be notified of students who are not in compliance with State Health Division Requirements.
HEALTH ASSESSMENT FORM

To the examining physician: please complete this physician’s form, with comments on all positive answers. Since this student has already been accepted for admission, the information supplied will not affect his/her status and will be used only as background for providing any needed care by the health services. It will not be released to anyone without the student’s consent.

Name _________________________________________________ Sex: □ F □ M

BP ____/____   Height _____ inches   Weight _____ lbs.   Corrected vision: Right 20/___ Left 20/___

Urinalysis: Sugar ___________________________  Albumin ___________________________  Micro ___________________________

Pap smear date (if completed): __________________ Result __________________ Prescription __________________

Hemoglobin (if indicated) ____________________________

Are there any abnormalities of the following systems? (If so, please describe briefly.)

Heart □ no □ yes

Head, ears, nose, or throat □ no □ yes

Cardiovascular □ no □ yes

Gastrointestinal □ no □ yes

Hernia □ no □ yes

Eyes □ no □ yes

Genitourinary □ no □ yes

Musculoskeletal □ no □ yes

Metabolic or endocrine □ no □ yes

Neuropsychiatric □ no □ yes

Skin □ no □ yes

Is patient currently taking any medication? □ no □ yes ____________________________

Does student have any known allergies? □ no □ yes ____________________________

Allergies to medications? □ no □ yes ____________________________

Recommendations for physical activity (P.E.): □ Unlimited □ Limited (explain) ____________________________

Do you have any recommendations regarding the care of this student? □ no □ yes If so, what? ____________________________

Is the patient now under treatment for any medical conditions? □ no □ yes Diagnosis: ____________________________

Is the patient now under treatment for any emotional condition? □ no □ yes Diagnosis: ____________________________

Is the student under treatment for any attention disorder or learning disorder conditions? □ no □ yes

If so, what? ____________________________

Medications: ____________________________

Specific academic accommodations required: ____________________________

Please send relevant medical records to us to help us coordinate and continue care. Thank you.

______________________________ ____________________________ _________________________
Health provider’s signature Please print last name Date

______________________________ ____________________________ _________________________
Address Phone: (______) FAX: (______)
STUDENT SELF-ASSESSMENT FORM

Please check appropriate column to indicate whether you or your immediate blood relatives have had any of the following health conditions: (We would appreciate your identifying parent, sibling, or grandparent under family, using the following codes for your grandparents: MGM=maternal grandmother, MGF=maternal grandfather, PGM=paternal grandmother, PGF=paternal grandfather)

<table>
<thead>
<tr>
<th>self</th>
<th>family</th>
<th>self</th>
<th>family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td></td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td>Kidney problems</td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td>Bladder infections</td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td>Allergies/hay fever</td>
<td></td>
<td>Thyroid disease</td>
<td></td>
</tr>
<tr>
<td>Varicose veins</td>
<td></td>
<td>Hepatitis/liver disease</td>
<td></td>
</tr>
<tr>
<td>Migraine headaches</td>
<td></td>
<td>Gallbladder disease</td>
<td></td>
</tr>
<tr>
<td>Recurrent headaches</td>
<td></td>
<td>Gastro/intestinal disorder</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Blood disorders</td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
<td>Depression/anxiety</td>
<td></td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td></td>
<td>Bipolar disorder</td>
<td></td>
</tr>
<tr>
<td>Gyn surgeries, concerns/problems—please list:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I am allergic to: ❏ penicillin ❏ aspirin ❏ sulfas ❏ other ❏

Do you take allergy shots? ❏ Yes ❏ No (We do not give allergy shots in our clinic, but will help with referral to a local allergist.)

Have your physical activities been restricted during the past year? ❏ Yes ❏ No

Comment

Chronic illness requiring special care or treatment? ❏ Yes ❏ No

Comment

Have you had any illness or injury or been hospitalized other than already noted? ❏ Yes ❏ No

Comment

Have you ever been diagnosed with a learning disability, attention deficit/ADD/ADHD and/or had, or do you have now, any specific learning needs? ❏ Yes ❏ No

Comment

Have you had any of the following:

<table>
<thead>
<tr>
<th>Psychiatric problems</th>
<th>Yes</th>
<th>No</th>
<th>Severe PMS</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sleep disorders/insomnia</td>
<td>Yes</td>
<td>No</td>
<td>Suicide attempt</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Yes</td>
<td>No</td>
<td>Alcohol problems</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Depression</td>
<td>Yes</td>
<td>No</td>
<td>Substance abuse problems</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>Yes</td>
<td>No</td>
<td>Psychiatric hospitalizations</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Bulimia</td>
<td>Yes</td>
<td>No</td>
<td>Anorexia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sexual/physical abuse or rape</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

To assist the counseling center with planning for the coming year, please answer the following:

I am interested in receiving individual counseling or therapy. ❏ Definitely ❏ Possibly ❏ Unlikely

If you have any other information of which staff should be aware or have questions regarding health needs or concern, please feel free to provide information on the back of this form and call and/or stop by the health services.

Student signature Date

Printed name
LIFESTYLE QUESTIONNAIRE
This questionnaire will help us to better serve your health needs by understanding your health practices.
All information is strictly confidential within health services.

Name ________________________________ Date __________________

☐ female  ☐ male;  ☐ on campus  ☐ off campus;  semester at Reed (1st, 2nd, etc.) __________

1. Do you consider your diet healthy?  Yes No
2. Do you take vitamins or nutritional supplements?  Yes No
   Are you vegan?  Yes No
   Are you vegetarian?  Yes No
   Other? ________________________________
3. Do you get adequate sleep?  Yes No
4. Do you exercise?  Yes No
5. Do you smoke or chew tobacco?  Yes No
6. Do you drink alcohol?  Yes No
7. Do you use drugs?  Yes No
8. If you are sexually active, do you practice safe sex?  Yes No  ☑ N/A
9. Do you feel that you engage in high-risk behaviors?  Yes No
10. Do you feel you manage stress well?  Yes No
11. Do you feel you have adequate support systems for handling stress?  Yes No
12. Do you take any prescribed medications?  Yes No  Specify ________________________________
13. Do you take any over the counter medications?  Yes No  Specify ________________________________
14. Are you allergic to any medications?  Yes No  Specify ________________________________
15. How would you assess your physical health overall?  
   ☑ Excellent  ☑ Very Good  ☑ Good  ☑ Fair  ☑ Poor
16. How would you assess your emotional health overall?  
   ☑ Excellent  ☑ Very Good  ☑ Good  ☑ Fair  ☑ Poor

REVIEWED

REED COLLEGE HEALTH SERVICES
3203 SE Woodstock Blvd, Portland OR 97202-8199
503/777-7281, FAX: 503/777-7209; Email: sattelyv@reed.edu