May 2006

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, be sure to let us know if questions arise.

[Signatures]

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 marked C 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.
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.

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.

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.

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.

Insurance coverage
All students are required to submit evidence of health insurance coverage or to purchase health insurance through the college. If you are considering remaining on your parents’ insurance plan, it is important that you understand the limits and benefits of their coverage. Many families are covered by managed care health plans, which limit considerably the extent of coverage.

Some questions to consider are: Does the service extend beyond emergency coverage, when the insured is outside of the geographic region defined by the plan? Can professionals not on the provider list established by the plan provide service? Is mental health care included in the plan, and to what extent? What level of pre-authorization and approval is required for services to be provided?

Many students are finding it advantageous to obtain the college’s comprehensive medical insurance plan and also to remain on their parents’ health plan. The cost of the Reed College plan is $545 per semester for the 2006-07 year, including the summer months when the college is not in session. The plan is tailored to meet the expenses most likely incurred by healthy college students.

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. Unless you return an insurance waiver form, the business office will bill you for the Reed College plan.

More information about insurance, and the insurance waiver form, can be found in this “Getting Started at Reed” packet.

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 contact 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

Last name (please print)    First    Middle    Social Security #

Home address
City    State    Zip    Country

Home phone    Email    Citizenship    Birthdate

FAMILY HISTORY

occupation    age if living    if deceased,    cause of death
presently    in good health?

FATHER

MOTHER

SISTER(S)

BROTHER(S)

INSURANCE INFORMATION

Policy holder    Policy holder social security #
Employer/carrier    Insurance company name
Insurance company address    Phone
Individual membership #    Group #
Type of coverage    Coverage to age    Expiration date

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)

Name of parent or guardian    Relationship
Address
City    State    Zip    Country
phone (work)    (home)

Please list alternate person in case the above individual cannot be reached:
Name    Relationship
Phone (work)    (home)

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:

<table>
<thead>
<tr>
<th>LAST NAME (PLEASE PRINT)</th>
<th>FIRST</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Virus</th>
<th>Date of immunization</th>
<th>Date of booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles (Rubeola)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles/mumps/rubella (MMR)*</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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-Diphtheria (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:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
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<tbody>
<tr>
<td></td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
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<td></td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
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<tr>
<td></td>
<td><em><strong><strong>/</strong></strong></em>/_____</td>
</tr>
</tbody>
</table>
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):

______________________________
MONTH        DAY        YEAR

**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).

______________________________
PHYSICIAN'S SIGNATURE

______________________________
DATE

______________________________
PHYSICIAN'S NAME (PLEASE PRINT)

______________________________
ADDRESS

______________________________
PHONE

**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.

______________________________
SIGNATURE

______________________________
DATE

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

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 ❏ sulfa ❏ 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:

Psychiatric problems ❏ Yes ❏ No  Severe PMS ❏ Yes ❏ No
Sleep disorders/insomnia ❏ Yes ❏ No  Suicide attempt ❏ Yes ❏ No
Anxiety ❏ Yes ❏ No  Alcohol problems ❏ Yes ❏ No
Depression ❏ Yes ❏ No  Substance abuse problems ❏ Yes ❏ No
Bipolar disorder ❏ Yes ❏ No  Psychiatric hospitalizations ❏ Yes ❏ No
Bulimia ❏ Yes ❏ No  Anorexia ❏ Yes ❏ No
Sexual/physical abuse or rape ❏ Yes ❏ No

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