

Comprehensive Student Health and Disability Report

Form 1 of 3

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

Were 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

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Immunization Record

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

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

Date of birth M D Y Student ID#

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

<p>MMR</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>2. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p>	<p>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.</p> <p>Students who have not complied with the MMR vaccination requirement and do not meet exemption criteria will experience registration holds or cancellations.</p>
<p>I meet the following exemption(s) and thus do not need the MMR immunization:</p> <p><input type="checkbox"/> My MMR titer report is attached and indicates I am immune.</p> <p><input type="checkbox"/> A signed physician or nurse practitioner statement is attached indicating I had the diseases. (Statement must include date.)</p> <p><input type="checkbox"/> 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.).</p> <p><input type="checkbox"/> I am an adherent to a religion whose teachings are opposed to immunization, and so I request to be exempted from the MMR immunization requirement.</p>	
<p>Signature of student _____ Date _____</p>	

<p>RECOMMENDED VACCINES</p> <p>DPT (diphtheria/tetanus)</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>2. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>3. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>4. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>Booster M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>Polio</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>2. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>3. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>4. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>Booster M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p>	<p>Varicella</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>2. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>Meningococcal</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>Hepatitis B</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>2. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>3. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>HPV</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>2. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>3. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p>	<p>OTHER VACCINES</p> <p>Hepatitis A</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>2. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>Twinrix (Hepatitis A and B)</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>2. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>3. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>Typhoid</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p> <p>Yellow Fever</p> <p>1. M <input type="text"/> <input type="text"/> D <input type="text"/> <input type="text"/> Y <input type="text"/> <input type="text"/></p>
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Comprehensive Student Health and Disability Report

Form 2 of 3

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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

Student ID#

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 3

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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? _____
