Comprehensive Student Health and Disability Report

Linfield University
900 SE Baker St
McMinnville, Oregon 97128-6894

Student Health, Wellness, and Counseling Center
Phone: 503-883-2535
Fax: 503-883-2633

internal use only
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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 Linfield personnel on a need-to-know basis only. Please return your completed form to the Student Affairs. Linfield University 900 SE Baker St. McMinnville, OR 97128

Student Information

Student ID number _____ Date _____

Name last _____ first _____ m.i. _____ Gender ☐ M ☐ F ☐ T ☐ NB

Address street _____ city _____ state _____ zip _____

Phone _____ E-mail _____

Cell phone _____ Marital status _____

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 Linfield 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 Contact:

Primary Name _____ Relationship _____

Address street _____ city _____ state _____ zip _____

Phone home _____ office _____ cell _____ E-mail _____

Medical Insurance Information: *Please attach a copy of front and back of insurance card*

Insurance Company Name _____ ID# _____ Group # _____

Address street _____ city _____ state _____ zip _____

Subscriber Name last _____ first _____ m.i _____ Date of birth: *m* *d* *y* _____

Family History

Were you adopted? ☐ yes ☐ no

Name	Year of birth	State of health	Age at death	Cause of death
Father				
Mother				
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, and mental illness.

CONFIDENTIAL

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

All information disclosed on this form will be kept confidential and shared with appropriate Linfield 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	Details: Identify question by number; include diagnosis, age or dates, and treatment.
2. Operation or serious injury	☐	☐	
3. Hospitalization	☐	☐	
4. Mumps	☐	☐	
5. Mononucleosis (Mono)	☐	☐	
6. German measles (Rubella)	☐	☐	
7. Hard measles (Rubeola)	☐	☐	
8. Chicken pox	☐	☐	
9. Tuberculosis	☐	☐	
10. BCG vaccine (T.B. vaccine)	☐	☐	
11. Adverse or allergic reaction to any medication	☐	☐	
12. Allergic reaction to food, insect bites, or other stimulus not related to medication	☐	☐	
13. List any medications you use.			
Have you ever had or been treated for any of the following?			
14. Serious disease of eyes, ears, nose, or throat	☐	☐	
15. Frequent or severe headaches or convulsions, or a severe head injury	☐	☐	
16. Lung disease, asthma, persistent cough, or shortness of breath	☐	☐	
17. High blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of heart or blood vessels	☐	☐	
18. Frequent or severe abdominal pain, hepatitis, problems with bowel movements, rectal bleeding, or other intestinal problem	☐	☐	
19. Sugar, protein, or blood in urine, or bladder or kidney problem	☐	☐	
20. A sexually transmitted infection (STI)	☐	☐	
21. Diabetes, thyroid, or other endocrine disorder	☐	☐	
22. Anemia or other disorder of the blood	☐	☐	
23. Bone, joint, or muscle problem; back pain; arthritis; physical deformity; or paralysis	☐	☐	
24. Hay fever, asthma, hives, or other allergy	☐	☐	
25. Severe acne, eczema, or other skin disorder	☐	☐	
26. Cancer or other tumor	☐	☐	
27. Mental health conditions	☐	☐	
28. A disorder not listed above (specify)	☐	☐	
Do you . . .			
29. Have a special diet? (Explain)_____	☐	☐	
30. Drink alcoholic beverages? (Specify type and number of drinks per week)	☐	☐	
31. Smoke or chew tobacco? Amount:_____ Years:_____	☐	☐	
32. Want support to decrease your smoking or tobacco use?	☐	☐	
33. Have you ever had an illness or disorder involving the reproductive system?	☐	☐	
If yes, please specify_____			
Female at birth Only			
34. Do you take birth control pills?	☐	☐	
35. Do you use any other form of contraception? (specify)	☐	☐	
Male at birth Only			
36. Have you ever had any disorder of the penis, testicles, or prostate?	☐	☐	

Tuberculosis Screening Form

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Do I need to have a tuberculosis screening test?

☐ **Yes** ☐ **No** I was born in a country with a high incidence of tuberculosis disease.*

☐ **Yes** ☐ **No** In the last five years, I lived in, traveled to, or emigrated from a country with a high incidence of tuberculosis disease.

If you answered yes to either question, **you do need screening**. Tests must be conducted within six months of the start of classes.
If you answered no to both questions, you do not need to complete this form.

*To determine if you have lived in a country with a high incidence of tuberculosis, download the American College Health Association's *"Tuberculosis Screening and Targeted Testing of College and University Students"*, http://www.acha.org/Publications/docs/ACHA_Tuberculosis_Screening_Apr2011.pdf and see Appendix A.
The United States has a low incidence of tuberculosis.

Student Information

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

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

Complete the section below only if tuberculosis screening is required.

Have you had a positive TB skin test or positive Quantiferon test at any time in the past? ☐ **Yes** ☐ **No**
If yes, go to Part II below.
If no, go to Part I below.

PART I

You must submit either **A)** a TB Skin Test, or **B)** a Quantiferon blood test (QFT).

A) If you choose a TB skin test, attach a report of the test (from within the last six months) or have your health care provider or health department complete the following:

Instructions for medical staff for TB skin test: test must consist of Mantoux intermediate strength PPD (0.1 ml intradermal).

Date administered: *m* _____ *d* _____ y _____

Date read: *m* _____ *d* _____ y _____

Result (**required**)_____mm in duration **If the test result is 10mm in duration or greater, go to Part II.**

Health Care Provider Authorized Signature:_____

Address:*street*_____*city*_____*state*_____*Phone*_____

B) If you choose a Quantiferon blood test (QFT), attach a copy of the QFT results (from a test within the last six months). QFT results are accepted from any country. If your QFT is positive, go to Part II.

PART II

You will need to have a chest X-ray three to six months before classes begin. Please attach the paper X-ray report (do not send the X-ray) and send it with this form.

Immunization Record

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Student Information

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

Date of Birth *m* _____ *d* _____ *y* _____ Student ID# _____

MMR

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 Linfield, 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 who do not meet exemption criteria will experience registration holds or cancellations.

1. ____/____/____ **2.** ____/____/____

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 health care provider statement is attached indicating I had the diseases. (Statement must include date of disease.)

☐ A signed health care provider statement is attached verifying I have a medical reason for not receiving the immunization (anaphylactic reactions to eggs, immunocompromised state, etc.).

☐ 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.

Signature of student _____ Date _____

RECOMMENDED VACCINES

DPT (diptheria/tetanus)
1. ____/____/____
2. ____/____/____
3. ____/____/____
4. ____/____/____

Booster: ____/____/____

Polio
1. ____/____/____
2. ____/____/____
3. ____/____/____
4. ____/____/____

Booster: ____/____/____

Meningococcal
1. ____/____/____

Hepatitis B
1. ____/____/____
2. ____/____/____
3. ____/____/____

HPV
1. ____/____/____
2. ____/____/____
3. ____/____/____

Varicella
1. ____/____/____
2. ____/____/____

OTHER VACCINES

Hepatitis A
1. ____/____/____
2. ____/____/____

Twinrix (Hepatitis A and B)
1. ____/____/____
2. ____/____/____
3. ____/____/____

COVID-19
1. ____/____/____
2. ____/____/____

Booster____/____/____
____/____/____

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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. Linfield's Student Health, Wellness and Counseling staff will review this information and, in some cases, will contact the student prior to the student's arrival on campus to make a connection and suggest possible resources. All information disclosed on this form will be kept confidential within the files of the Student Health, Wellness, and Counseling Center. Please see the bottom of this page for how you can voluntarily choose to authorize a release of information from this page in a way that might be beneficial for you.

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	☐	☐	_____
3. An anxiety disorder	☐	☐	
4. An eating disorder	☐	☐	_____
5. Bipolar disorder	☐	☐	
6. Obsessive-compulsive disorder	☐	☐	_____
7. An anger management issue	☐	☐	
8. PTSD	☐	☐	_____
9. ADD/ADHD	☐	☐	
10. Suicidal ideation	☐	☐	_____
11. A suicide attempt	☐	☐	
12. A sleep disorder	☐	☐	_____
13. Panic disorder	☐	☐	
14. A learning disability	☐	☐	_____
15. Autism Spectrum Disorder or a similar diagnosis	☐	☐	
16. An antisocial or conduct disorder	☐	☐	_____
17. Alcohol or substance abuse or dependence	☐	☐	
18. Are you now taking, or have you ever taken medication for any of the above? If yes, specify medication and dates at right.	☐	☐	_____
19. Do you intend to begin or continue psychotherapy during college?	☐	☐	
20. Have you been hospitalized for a psychiatric disorder?	☐	☐	_____
21. Have you been treated for alcohol and/or drug addiction? (specify dates)	☐	☐	

Read the following only if you have marked "Yes" to any of the above items.

If you have a history of any of the conditions listed above, you can choose to authorize the staff of Student Health, Wellness, and Counseling Center to alert a small group of other key professional staff at Linfield. These professional staff members comprise our Student Support and Care Team, which is dedicated to the academic success of our students. With your authorization, these staff would be alerted that you are a student who may need additional support due to health reasons. No further information would be released. If you consent to this disclosure and you experience significant academic challenges, key staff may be better prepared to recognize and respond to your needs. Providing this authorization is voluntary.

☐ **Yes**, by signing below, I authorize the staff of the Student Health, Wellness, and Counseling Center to identify me to the Student Care and Support Team as a student who may need additional support due to health reasons.

Signature of student _____ Date _____

☐ **No**, I do not authorize the staff of the Student Health, Wellness, and Counseling Center to identify me to the Student Care and Support Team as a student who may need additional support due to health reasons.

Disclosure of any condition on this form does not constitute disclosure of a disability or a request for academic or housing accommodations. If you believe that you have a disability and want to receive support or accommodation, please contact Linfield Learning Support Services office at lss@linfield.edu

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Serving Students with Disabilities and Learning Differences

Please include this page when you return your completed report to the Student Health, Wellness, and Counseling Center. Linfield Student Health, Wellness and Counseling Center works closely with The Office of Linfield Learning Support Services to help design the best supports for you during your time at Linfield University. The information provided on this form will be used by the Student Health, Wellness, and Counseling Center staff to better understand what your needs might be. This form is not intended to serve as a request for Academic or Housing Accommodations based on a disability or diagnosis. For accommodation requests, contact The Office of Linfield Learning Support Services at lss@linfield.edu or 503-883-2562.

Student Support Services

Linfield is committed to serving the needs of our students with disabilities and learning differences. Professional staff in the Office of Learning Support Services is available to ensure that these students receive all the benefits of a comprehensive selection of services. Services, advising, and accommodations are always the result of an active partnership between students and Learning Support Services staff. Learning Support Services staff addresses the academic needs of students with documented physical, sensory, psychological, and learning disabilities. Accommodations may include, but are not limited to, note takers, tutors, sign language interpreters, taped textbooks, extended time on exams, and enlargement of written materials. Accommodations are available to those students entitled to them under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.
All information disclosed below will be kept confidential in the files of the Student Health, Wellness and Counseling Center and The Office of Learning Support Services. This information will be shared with appropriate Linfield University personnel on a need-to-know basis only.

Requesting Accommodations

While you may request accommodations at any time during your studies at Linfield, we encourage you to give us as much advance notice as possible so that we can develop the best plan to respond to your needs. If you think you might need to request accommodations, we encourage you to include documentation of your condition and send directly to The Office of Learning Support Services at your earliest convenience. For more information, visit www.linfield.edu/learning-support.com

Student Information

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

Student Support List

We recognize that some students may have a condition that could impact learning, but for which students do not want academic accommodations per se (e.g., note takers, extended test time, etc.) *If you have any condition that may impact your learning, we encourage you to check the appropriate box below.* This will allow our staff to provide better support should you encounter academic challenges in the coming year. Completion of this section is optional.

- ☐ Learning Disability
- ☐ ADHD
- ☐ Autism Spectrum Disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Other disability (explain below)

Request for Information on Accommodations

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. What types of accommodations do you anticipate using at Linfield?

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