

Comprehensive Health History and Academic Support and Disability Services Report

SOUTHERN OREGON UNIVERSITY
1250 Siskiyou Blvd.
Ashland, Oregon 97520

Student Health and Wellness Center
541-552-6137
541-552-6693 fax

General Information

The information provided in this report is confidential and is maintained within the Student Health and Wellness Center. If section 5 is completed the information in that section will be sent to Academic Support and Disability Services where it will be maintained confidentially. Sections 1 and 2 are required for all students. Your confidential health information cannot be released without your written consent with the exceptions as allowable or required by law. For more information see www.sou.edu/health.

Student Information

Name Last _____ First _____ M.I. _____
Address Street _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ E-mail _____
SSN# _____ Student ID# _____ Marital Status _____ No. of Children _____
Place of Birth City _____ State _____ Country _____ Gender _____ Date of Birth _____
Are you a veteran? yes no Location and dates of service operation? _____

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

I hereby give my permission to the physician selected by SOU Student Health and Wellness Center to hospitalize, secure proper treatment for, and order injections, anesthesia or surgery for my child with the understanding that every effort will be made to contact me in case of medical emergency.

Parent/guardian signature _____ Date _____
Print name of parent/guardian _____ Phone _____
Address Street _____ City _____ State _____ Zip _____

Emergency Information

A. Contacts

Primary Relationship _____
Name Last _____ First _____ M.I. _____
Address Street _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ E-mail _____

Secondary Relationship _____
Name Last _____ First _____ M.I. _____
Address Street _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____ E-mail _____

B. Care and Treatment Provider(s)

Should a medical need arise, will you use the Student Health & Wellness Center? yes no
If no, please list **current health care provider** _____ Phone _____

C. Allergies *For all yes answers please list and/or describe.*

	yes	no
Do you have a life threatening allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to or have adverse reaction to any medication? Including over the counter medication?	<input type="checkbox"/>	<input type="checkbox"/>
Are you allergic to latex, tape, iodine?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have strong allergic reaction to food, insect bites, or other stimulus?	<input type="checkbox"/>	<input type="checkbox"/>

D. Medications

Are you currently taking prescription medications (including birth control)?

Do you regularly take over-the-counter medications?

Do you regularly take alternative treatments, herbs, vitamins?

E. Blood type

Do you know your blood type yes no If yes please specify _____

Name Last _____ First _____ M.I. _____ Date _____ Student ID# _____

Immunization History**Measles**

Students who do not provide proof of immunity to rubeola measles will have a hold placed on their account which will prevent further registration.

According to Oregon State law, all full-time students entering a college or university who were born after December 31, 1956, must provide proof of immunity to rubeola (hard measles).

Please check one of the following:

- I have had two doses of measles vaccine on or after my first birthday and they were given at least 30 days apart. (If given between 1/1/63 and 12/31/67, the vaccine must have been a LIVE vaccine to be acceptable. Measles vaccines given before 1963 are not acceptable.) Please provide dates of immunizations: 1st dose ___/___/___ 2nd dose ___/___/___
- I do not know the date of my first measles vaccination, but I had my second measles vaccination after November 1989. Date of 2nd dose ___/___/___
- I meet the following exemption(s) and thus do not need the measles immunization:
- My measles (rubeola) titer report is attached and indicates I am immune to measles.
 - A signed physician or nurse practitioner statement is attached indicating the dates I had rubeola measles.
 - A signed physician or nurse practitioner statement is attached verifying a medical reason for not receiving the immunization (anaphylactic reactions to eggs, immunocompromised state, etc.).
 - My religious beliefs prohibit my use of the immunization.

I attest that the above information is true. Student signature is required.

Name Last _____ First _____ M.I. _____

Signature of student _____ Date _____

Parent/Guardian (if student under 18) _____ Date _____

Tuberculosis (TB) Control

- Have you ever had TB? yes no
- Have you been a close contact of a person with infectious TB? yes no
- When was your last TB test? date _____ never don't know
- Have you ever had a positive TB test? yes no
- Have you ever had BCG vaccine? yes no

Other Immunizations- please check all that apply

- Tetanus (DT, Td, DTaP, DTP, Tdap) ___/___/___
- Polio #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___
- Varicella (Chicken Pox) #1 ___/___/___ #2 ___/___/___; Had disease at age ___
- Hepatitis A #1 ___/___/___ #2 ___/___/___
- Hepatitis B #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
- HPV #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
- Meningococcal ___/___/___

The SHWC recommends first year students living in residential halls consider with your health care provider, or local public health department, the meningococcal vaccine.

Name Last _____ First _____ M.I. _____ Date _____ Student ID# _____

Mental Health History

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Should a mental health issue arise, will you use the SHWC Counseling services? yes no Other provider _____

Do you:

Smoke? Amount _____ Years _____ Chew? Amount _____ Years _____

Drink alcoholic beverages? Type _____ Number of drinks per week _____

Have you consumed ≥5 alcoholic drinks in one setting in the last six months? yes no

Regularly use other drugs (marijuana, stimulant, diet pills, steroids, illicit, etc.)? Please specify: yes no

Have you ever experienced any of the following:

yes no

Anger management issue

Depression

Anxiety

Anorexia, bulimia or other eating disorder

Asperger/Autism Spectrum Disorders

Bipolar disorder

Obsessive Compulsive Disorder (OCD)

Post Traumatic Stress Disorder (PTSD)

ADD/ADHD (Attention deficit)

Schizophrenia

Suicide attempt

Serious suicidal thoughts

Cutting or self mutilation

Domestic violence

Sexual abuse

Sleep disorder

Panic disorder

Brain injury with subsequent behavioral symptoms

Anti-social or conduct disorder

Alcohol or substance abuse or dependence

Are you now or have you ever taken medication for any of the above? (specify medications and dates)

Are you now or have you ever been in counseling for any of the above?

Have you ever been admitted to a hospital for a suicide attempt?

Have you ever been hospitalized for a psychiatric disorder?

Have you been treated for alcohol and/or drug addiction?

Inpatient? Outpatient?

If yes, please provide age, treatment provider name and location

Name Last _____ First _____ M.I. _____ Date _____ Student ID# _____

Academic Support Services And Disability Accommodation

If you have struggled academically in the past or suspect you may have learning challenges, we can work with you to provide access to various support services across campus. If a learning disability or ADD/ADHD may be suspected, we can help coordinate testing with practitioners and learning specialists in the area to determine if some sort of disability is, indeed present. SOU's health insurance plan may cover a portion of the cost of testing for students who have purchased coverage.

If you have physical or mental health issues which may impact your academic life while at Southern Oregon University, you may also be eligible for support and we welcome you to inquire about participating in our services.

When you fill out and return this form, you will receive information on SOU's Disability Services program and other academic support programs. You can learn more about us by consulting our website and the DSS Student Handbook at www.sou.edu/access/dss.

You can also call our office at (541) 552-6213 to schedule an appointment with a Disability Services staff member to talk about questions or concerns you may have about our program, to begin the process of registering for services, or to learn more about academic supports and testing options.

The information you provide below will allow us to better anticipate your needs upon your arrival at Southern Oregon University.

Do you feel you could benefit from assistance with any of the following?

Please check all that apply, and we will contact you with relevant information:

- Math Tutoring
- Writing Tutoring
- Study Skills
- Technology Support for Learning
- Specific Learning Strategies for Challenging Classes
- Time Management
- Note Taking
- Stress Management
- Organizational Skills
- Breaking larger projects into smaller tasks
- Test Taking Strategies
- Test Anxiety
- Memory Aids and Strategies
- Reading Speed
- Reading Comprehension
- Basic Computer Skills
- Listening/Hearing devices
- American Sign Language Interpreting
- Assistive Technology

Disability Services for Students addresses the academic needs of students with documented physical, psychological, and learning disabilities.

Accommodations may include, but are not limited to, note takers, sign language interpreters, testing accommodations, alternate format texts, 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 and meet with the DSS Staff for an intake to implement accommodations at SOU.

Name Last _____ First _____ M.I. _____ Date _____ Student ID# _____

Health Concerns or InterestsWhat are your major health concerns, if any, as you come to Southern Oregon University? *(check all that apply)*

- | | |
|---|---|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Weight gain/loss/maintenance |
| <input type="checkbox"/> Fitness | <input type="checkbox"/> Healthy eating |
| <input type="checkbox"/> Avoiding illness | <input type="checkbox"/> Getting enough sleep |
| <input type="checkbox"/> Avoiding tobacco | <input type="checkbox"/> Avoiding alcohol |
| <input type="checkbox"/> Avoiding other drugs | <input type="checkbox"/> Gambling addiction |
| <input type="checkbox"/> Video Games | <input type="checkbox"/> Transitioning to university life |
| <input type="checkbox"/> Money | <input type="checkbox"/> Relationships |
| <input type="checkbox"/> Peer Pressure | |
| <input type="checkbox"/> Other _____ | |

What kinds of health-oriented groups would you like to see at Southern Oregon University? *(check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Eating & Body Image Support Group | <input type="checkbox"/> Veteran's Support Group |
| <input type="checkbox"/> AA (Alcoholics Anonymous) | <input type="checkbox"/> NA (Narcotics Anonymous) |
| <input type="checkbox"/> LGBTQI | <input type="checkbox"/> Weight Watchers |
| <input type="checkbox"/> Recovery Group (Based off 12-Steps) | <input type="checkbox"/> Walking/Running Club |
| <input type="checkbox"/> Other _____ | |