REED

REED COLLEGE HEALTH SERVICES
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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.

_____ Sex: F_____ M_____
LAST NAME FIRST NAME

BP: _____/_____ **Height:** _____ inches **Weight:** _____ lbs. **Corrected Vision:** Right 20/ _____ Left 20/ _____

Urinalysis: Sugar _____
Albumin _____
Micro_____
Hemoglobin: (if indicated)_____

Pap Smear: (if completed) Date _____
Result _____
Prescription _____
_____

Are there any abnormalities of the following systems? Please describe briefly below: _____

_____

1. Heart	yes _____	no _____	7. Genitourinary	yes _____	no _____
2. Head, ears, nose, or throat	yes _____	no _____	8. Musculoskeletal	yes _____	no _____
3. Cardiovascular	yes _____	no _____	9. Metabolic/endocrine	yes _____	no _____
4. Gastrointestinal	yes _____	no _____	10. Neuropsychiatric	yes _____	no _____
5. Hernia	yes _____	no _____	11. Skin	yes _____	no _____
6. Eyes	yes _____	no _____			

Is patient currently taking any medication? _____

Does student have any known allergies? _____

Allergies to medications? _____

Recommendations for physical activity (P.E.): Unlimited _____

Limited _____

Do you have any recommendations regarding the care of this student? yes _____ no _____

If so, what? _____

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

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

Is the student under treatment for any attention disorder or learning disorder condition? yes _____ no _____

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

2008