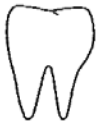
H. Health and Wellness	
Intermediate	
Knows how to obtain a copy of personal immunization records and medical history	H-64 through 73; H-74 through 89 (F, G, H, I, J)
Knows own blood pressure and pulse rate	http://kidshealth.org/teen/diseases_conditions/heart/hypertension.html
Knows how to use simple in-home medical items (thermometer, pregnancy test, etc.)	Individualized instruction
Knows (if applicable) how to care for and maintain own medical equipment (inhaler, nebulizer, glucometer, epi pen, asthma pump, etc.)	Individualized instruction
Understands diagnoses, allergies and if medically complex – special care needs with associated prognosis and treatment.	Individualized instruction
Knows how to nurse self through a cold or the flu and care for own minor injuries	H-61 through 62
Knows how to make and keep appointments with health care professionals (doctor, dentist, clinician, etc.)	H-60
Understands labs and important tests as they relate to own special healthcare needs	http://kidshealth.org/teen/cancer_center/diagnostic_tests/test_bmp.html#cat20119
Understands issues such as confidentiality, HIPAA and consents	http://whatishipaa.org/ http://www.hipaa.com/
Understands the importance of sleep in relation to daily functioning	H-90 through 93
Understands what medical insurance is and why it is important	H-94 through 95
Knows how to determine when to go to an emergency room and when to make an appointment with the family doctor or walk-in clinic	H-96

PERSONAL HEALTH CARE

Taking care of your personal health and obtaining the necessary health information and/or services is an important life-long task. You should also know your own health history (any illnesses, immunizations, allergies, etc.). Keeping yourself healthy involves not only getting proper medical treatment when you're sick, but also preventing health problems as well.

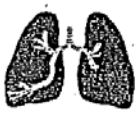
Consider the following examples:



Niklaus has a cavity and is supposed to make an appointment with the dentist. However, he does not follow through. What long-term and short-term consequences do you think Niklaus might suffer by not scheduling a dentist's appointment?

Short Term:

Long Term:



Leah is a cheerleader at her high school. There is a history of asthma in her family. Recently, she has had trouble catching her breath, oftentimes during her cheerleading practice. However, her breathing always seems to improve after a little while. Leah is afraid that if she tells someone about her problem, she won't be able to be a cheerleader anymore. She thinks that her difficulty breathing might just go away by itself. Do you think Leah is right? What would you do?

Independent Living Skills Module II

Take some time and answer the questions below with a foster parent, staff, or social worker to evaluate your personal health care needs. Mark those questions that need some follow-up, and plan with your foster parent, program staff, and/or social worker how you will get the information or services you need.

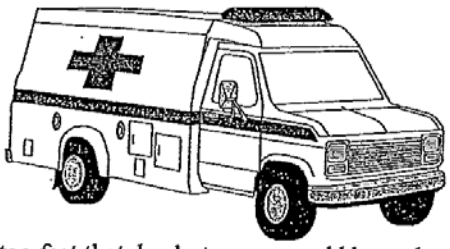
	YES	NO
Do you have a Medical Passport?	☐	☐
Do you have any questions about the information in the passport?	☐	☐
Has anyone gone over the information in the Passport with you?	☐	☐
Do you know when your last medical checkup was?	☐	☐
Do you know when your last dental checkup was?	☐	☐
Is your general health good?	☐	☐
Do you have a family history of any particular disease?	☐	☐
Do you have any allergies?	☐	☐
Are you taking medication or getting any regular treatments?	☐	☐
Did either the doctor or dentist suggest you make another appointment to have a problem followed?	☐	☐
Do health problems often interfere with your daily activities (keep you out of work, school, sports, etc.)?	☐	☐
Do you have a lot accidents or injuries?	☐	☐
Do you think you have a problem with alcohol or drugs?	☐	☐
Do the people you live with or your friends think you have a problem with alcohol or drugs?	☐	☐
Do you use birth control?	☐	☐
Do you have a doctor that you feel comfortable seeing?	☐	☐
Is there any health problem you'd like to have checked or a question you'd like to ask if the service was free and confidential (just between you and the doctor)?	☐	☐
Do you see a counselor or therapist?	☐	☐
If not, would you like to have someone with whom you could discuss your feelings and concerns?	☐	☐

Independent Living Skills Module II

My Personal Health Care Needs:

I need to follow up on...	*...by getting information or services from...*
	→
	→
	→
	→
	→

It is important to keep track of all your medical records. Be sure to put them in a safe and easily accessible place -- maybe your document portfolio. Not even doctors are able to read your mind. They need information to treat you properly. In a medical emergency or during a regularly scheduled doctor's visit, the more information you can provide to the medical care staff, the better they will be able to care for you.



Jan knew Jack was driving too fast that day but never would have thought there might really be a car crash. Nevertheless, here they were in an ambulance on the way to the emergency room. The EMTs (Emergency Medical Technicians) asked Jan if she was allergic to a list of things, and she had no idea whether she was or not.

Why did the EMTs ask Jan that question?_____

_____

_____

What information could Jan give them that would be helpful?_____

_____

_____

Independent Living Skills Module II

FAMILY MEDICAL HISTORY

Family medical history is very important. Your Medical Passport should include a fair amount of this information, so be sure to have a personal copy for your own records.

If you do not have much family health history information available to you, you should ask your social worker, foster parent, or staff to help you obtain the health history.

Family History

Have any of your blood relatives (brothers, sister, parents, grandparents) ever had any of the Following medical problems?

- ☐ Diabetes
- ☐ TB Skin test (positive results)
- ☐ High blood pressure
- ☐ Anemia
- ☐ Heart attack before the age of 60
- ☐ Kidney problem
- ☐ Mental retardation
- ☐ Learning problem
- ☐ Arthritis
- ☐ Other: _____
- ☐ Migraine headaches
- ☐ Alcohol or drug problem
- ☐ Epilepsy, convulsions, or seizures
- ☐ Psychiatric problems
- ☐ Stroke
- ☐ Birth defects
- ☐ Death at a young age
- ☐ Stomach or intestinal problems
- ☐ Asthma
- ☐ Cancer (Type: _____)

Let's look at Bob's example:

Bob is 17 years old and has been in foster care for two and a half years. Recently, he has been suffering really bad headaches which aspirin doesn't seem to help. He and his foster mother are at the doctor's office now, where Bob is trying to fill out the health questionnaire the nurse has given him. Bob is having a hard time answering some of the medical history questions, especially those about his sisters, brothers, parents, and grandparents.

What should Bob do? _____

_____

_____

Independent Living Skills Module II

Who could help him? _____

_____

_____

What should he tell the doctor or nurse? _____

_____

_____

What can he do for "next time" to be better prepared for this kind of thing? _____

_____

_____

What section in the Medical Passport offers some information that will help? _____

_____

_____

Do you need to obtain more information? If so, use the chart below to plan how you will get additional information about your medical history:

I need more information about...		Strategy
	⇨	
	⇨	
	⇨	
	⇨	
	⇨	

ACTIVITY

Here is a sample Health Questionnaire, similar to one that you might be asked to fill out when visit a new doctor or clinic. Answer the questions that you know and put a question mark (?) next to those you don't know. Then review this questionnaire with your social worker and foster parent or program staff to help you find the missing information.

Health Questionnaire

Name :

Address :

Date of Birth :

What questions or health problems would you like to see the doctor about today? _____

Are you taking any medication? ☐ Yes ☐ No

If Yes, what medicines do you take? _____

Medical History

Where were you born? _____ Hospital

_____ City

How much did you weigh at birth? ☐ lbs. and ☐ oz.

Did your mother have any problems during her pregnancy? If so, describe._____

Did she take any medication?_____

Were there any complications with the birth?_____

Independent Living Skills Module II

Have you ever been admitted to the hospital? ☐Yes ☐No

If yes, please list the dates, hospitals, and reasons for hospitalizations: _____

_____

Have you ever had an allergic reaction (to medicine, food, a bee sting, etc.)? ☐Yes ☐No

If yes, list the substance to which you are allergic: _____

_____

Have you ever had surgery (operations)? ☐Yes ☐No

If yes, please describe: _____

_____

Have you ever had any broken bones or any serious injuries? ☐Yes ☐No

If yes, please describe: _____

_____

Check any of the following illnesses and health problems that you have had or presently have:

- ☐ Anemia
- ☐ Asthma
- ☐ Hay fever
- ☐ Chicken Pox
- ☐ Measles
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Illness (other than colds, flu, etc.)
- ☐ Stomach/intestinal problems
- ☐ Kidney problem
- ☐ Blood clots or vein problems
- ☐ Hepatitis, jaundice
- ☐ Urinary tract infection
- ☐ Vaginal infection
- ☐ Short or tall for age
- ☐ Overweight
- ☐ Underweight
- ☐ Mononucleosis
- ☐ +TB Test (positive results)
- ☐ High blood pressure
- ☐ Migraine headache
- ☐ Seizures (convulsion, epilepsy)
- ☐ Thyroid problem
- ☐ Concussion
- ☐ Cancer
- ☐ Back/joint pain
- ☐ Pelvic infection
- ☐ Uterus or ovary problem
- ☐ Pregnancy
- ☐ Miscarriage or abortion
- ☐ Venereal disease (VD)
- ☐ Trouble seeing from a distance (near-sightedness)
- ☐ Trouble seeing things close up (far-sightedness)
- ☐ Wear glasses / contact lenses

Independent Living Skills Module II

- ☐ Frequent headaches
- ☐ Frequent tiredness
- ☐ Can't get to sleep easily / insomnia
- ☐ Sleep too much
- ☐ Cold or heat intolerance
- ☐ Dizziness
- ☐ Fainting or passing out
- ☐ Skin problem
- ☐ Severe acne
- ☐ Difficulty hearing
- ☐ Earache
- ☐ Wheezing
- ☐ Cough
- ☐ Heart skips a beat / palpitations
- ☐ Heart races
- ☐ Stomach pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Ringing in ears
- ☐ Sore that doesn't heal or change in wart or mole
- ☐ Blurred vision
- ☐ Constipation
- ☐ Nosebleeds
- ☐ Gum or mouth pain
- ☐ Recent toothache
- ☐ Breast lump
- ☐ Shortness of breath
- ☐ Difficulty with bowel movements
- ☐ Infrequent bowel movements
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Bed wetting
- ☐ Bleed or bruise easily
- ☐ Excessive thirst

List any other illnesses or health problems below:

Independent Living Skills Module II

Females Only: Visit to the gynecologist

Your age when you first got your period _____

Cycle length (How long does your period usually last?) _____

Irregular (Does the time of your period change from month to month? Yes ☐ No ☐

On what date did your last period start? _____

Cramps Yes ☐ No ☐

Excess bleeding with period Yes ☐ No ☐

Vaginal discharge Yes ☐ No ☐

Have had a pelvic (internal) exam before? Yes ☐ No ☐

Date of last pelvic exam _____

History of past pregnancy: Have you ever been pregnant? Have you had a miscarriage or abortion? (List responses and dates below.)

_____

Males and Females

Are you sexually active? ☐Yes ☐No

Check all methods of birth control you use:

- ☐ Condoms (rubbers)
- ☐ Birth control pills
- ☐ Diaphragm and spermicidal jelly
- ☐ Contraceptive foam or suppositories
- ☐ Sponge
- ☐ IUD
- ☐ Withdrawal
- ☐ Rhythm
- ☐ Norplant
- ☐ Depo-Provera

Independent Living Skills Module II

Substance Use

Do you smoke cigarettes? ☐Yes ☐No

If yes, how many cigarettes do you smoke a day? _____

How many years have you been smoking? _____

Have you ever tried to stop? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No

If yes, what kind of alcohol do you usually drink? _____

_____

How often do you drink? _____

Why do you usually drink? _____

_____

How much do you usually drink on those days that you do drink? _____

Do you ever drink by yourself? ☐Yes ☐No

Do any of your friends use alcohol? ☐Yes ☐No

Do you use drugs? ☐Yes ☐No

Have you used any of the following drugs in the past month?

Marijuana ☐Yes ☐No
Cocaine ☐Yes ☐No
Acid ☐Yes ☐No
Speed ☐Yes ☐No
Others (please list)_____

Do you use any needle drugs? ☐Yes ☐No

If yes, which types? _____

Are you worried about your drug or alcohol use? ☐Yes ☐No

If yes, please describe. _____

_____

_____

Is anyone else worried about your drug or alcohol use? ☐Yes ☐No

Would you like to talk to someone about your use of substances? ☐Yes ☐No

Health Information Form-*for Adults*

A. Identification

Name (Last) (First) (Middle)

Maiden Name

Primary Address

City | State | Zip | Country

Alternate Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | Email Address

Date of Birth | Sex: ☐ Male ☐ Female

Height | Weight | Eye Color | Hair Color

Race | Birthmark/Scars

Blood/RH Type | Special Conditions | Marital Status

Occupation

Company Name

City | State | Zip Code | Country

Phone Number | Languages Spoken

Primary Health Insurance Carrier | Policy Number

Secondary Health Insurance Carrier | Policy Number

B. Emergency Contacts

In Case of Emergency, Notify: Primary Contact

Name (last) (First) (Middle)

Relationship

Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | Email Address

In Case of Emergency, Notify: Secondary Contact

Name (last) | Name (middle) | Name (first)

Relationship

Address

City | State | Zip Code | Country

Home Phone | Work Phone

Cell Phone | Email Address

In Case of Emergency, Notify: Medical Contact

Doctor *(Indicate Specialty)*

Phone Number

Health Information Form-*for Adults*

Dentist	Telephone Number
Pharmacy	Telephone Number

C. Healthcare Provider

Healthcare Provider Specialty	Primary Care Physician ☐ Yes ☐ No	Phone	Emergency Phone No.(after hours)
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City / State / Zip Code / Country			

Healthcare Provider Specialty	Primary Care Physician ☐ Yes ☐ No	Phone	Emergency Phone No.(after hours)
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City / State / Zip Code / Country			

Healthcare Provider Specialty	Primary Care Physician ☐ Yes ☐ No	Phone	Emergency Phone No.(after hours)
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City / State / Zip Code / Country			

Health Information Form-*for Adults*

Healthcare Provider Specialty	Primary Care Physician ☐ Yes ☐ No	Phone	Emergency Phone No.(after hours)
Name		Email Address	
Group or Association		Fax	
Address		Web Address/URL	
City / State / Zip Code / Country			

D. Insurance Providers

Insurance Provider Type				E-mail Address	Fax
Company Name				Web Address/ URL	
Address				Primary Insured Person-Name	Social Security No.
City	State	Zip Code	Country	Name of Employer	
Contact – Name		Phone		Address	
Identification-Group Number		Member(ID) Number		City / State / Zip Code / Country	
Contact Information-Phone		Emergency Phone No.(after hours)		Phone Number	

Insurance Provider Type				E-mail Address	Fax
Company Name				Web Address/ URL	
Address				Primary Insured Person-Name	Social Security No.
City	State	Zip Code	Country	Name of Employer	
Contact-Name		Phone		Address	
Identification-Group Number		Member(ID) Number		City / State / Zip Code / Country	
Contact Information-Phone		Emergency Phone No.(after hours)		Phone Number	

Insurance Provider Type	E-mail Address	Fax

Health Information Form-*for Adults*

Company Name				Web Address/ URL			
Address				Primary Insured Person-Name	Social Security No.		
City	State	Zip Code	Country	Name of Employer			
Contact-Name	Phone			Address			
Identification-Group Number	Member(ID) Number			City	State	Zip Code	Country
Contact Information-Phone	Emergency Phone No.(after hours)			Phone Number			

E. Legal Documents/Medical Directives

☐ Living Will ☐ Durable Power of Attorney for Healthcare ☐ Power of Attorney				Fax			
Document Location (Physical Location)				Contact (Name of person who has access to the document)			
Location Name (for example Bank of America)				Address			
Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Contact Information			
Legal Representative (Name of person who you have assigned legal authority)				Home Phone	Cellular Phone		
Address				Pager	E-mail Address		
City	State	Zip Code	Country	Work Phone	Work E-mail Address		
Contact Information				Fax			
Home Phone	Cellular Phone			Date Filed			
Pager	E-mail Address			Organ Donation:			
Work E-mail Address	Work Phone			Organ Donor ☐ Yes ☐ No	State Where Registered		

☐ Living Will ☐ Durable Power of Attorney for Healthcare ☐ Power of Attorney	Fax
Document Location(Physical Location)	Contact (Name of person who has access to the document)

Health Information Form-*for Adults*

Location Name (for example Bank of America)				Address			
Address				City	State	Zip Code	Country
City	State	Zip Code	Country	Contact Information			
Legal Representative (Name of person who you have assigned legal authority)				Home Phone		Cellular Phone	
Address				Pager		E-mail Address	
City	State	Zip Code	Country	Work Phone		Work E-mail Address	
Contact Information				Fax			
Home Phone		Cellular Phone		Date Filed			
Pager		E-mail Address		Organ Donation:			
Work E-mail Address		Work Phone		Organ Donor ☐ Yes ☐ No		State Where Registered	

F. Medical History (Check appropriate)

	Date of Onset		Date of Onset
☐ Acquired Immunodeficiency Syndrome (AIDS) or HIV Positive:		☐ High Blood Pressure	
☐ Arthritis		☐ Hypoglycemia	
☐ Asthma		☐ Jaundice	
☐ Bronchitis		☐ Kidney Disease	
☐ Cancer		☐ Low Blood Pressure	
☐ Chlamydia		☐ Mental Retardation	
☐ Diabetes		☐ Pain or Pressure in Chest	
☐ Dizziness		☐ Palpitations	
☐ Emphysema		☐ Periods of unconsciousness	
☐ Epilepsy		☐ Rheumatic Fever	
☐ Eye Problem		☐ Rheumatism	
☐ Fainting		☐ Seizures	
☐ Frequent or Severe Headaches		☐ Shortness of Breath	
☐ Glaucoma		☐ Stomach Liver or Intestinal Problems	
☐ Gonorrhea		☐ Syphilis	
☐ Hearing Impairment		☐ Tuberculosis	
☐ Heart Condition		☐ Tumor	
☐ Hemodialysis		☐ Thyroid Problems	

Health Information Form-*for Adults*

☐ Herpes		☐ Urinary Tract Infection	
☐ High Blood Cholesterol		☐ Other	

G. Infectious Diseases

Disease	Age	Date	Remarks
Chicken Pox			
Hepatitis			
Measles			
Mumps			
Pertussis /Whooping Cough			
Pneumonía			
Polio			
Rubella			
Scarlet Fever			
Other			

H. Immunizations

Immunization for	Booster 1		Booster 2		Booster 3	
	Age	Date	Age	Date	Age	Date
Diptheria						
Hepatitis B						
Measles						
Mumps						
Pertussis/Whooping Cough						
Polio						
Rubella						
Smallpox						
etanus						
uberculosis						

Health Information Form-*for Adults*

Typhoid						
Other						

I. Allergies/Drug Sensitivities

Allergy/Sensitivity Type *(include medications foods environmental or other)*	**Reaction**	**Date last Occurred**	**Treatment**

Health Information Form-*for Adults*

J. Family Member History

	Mother	Father	Sibling(s)	Grandparent(	Children
Enter ages of relatives					
If deceased, indicate age and cause of death					
Check all items that apply for their present state of health or any illnesses they have had					
Alcoholism					
Arthritis					
Asthma					
Cancer					
Diabetes					
Emphysema					
Glaucoma					
Heart Condition					
Hemodialysis					
Hepatitis					
High Blood Cholestrol					
High Blood Pressure					
Kidney Disease					
Mental Retardation					
Rheumatic Fever					
Seizures					
Smoking					
Stomach Liver or Intestinal Problems					
Stroke					
Thyroid Disorders					
Jberculosis					
umor					

Health Information Form-*for Adults*

Other					

K. Lifestyle

☐ Alcohol	Drink(s) Per Week	Number of Years
☐ Smoking	Pack(s) Per Day	Number of Years
☐ Exercise	Type(s) of Exercise	Days Per Week

L. Health Log (Noninfectious major illnesses. Include pregnancies and childbirth)

Date Diagnosed	Doctor	Nature of Health Problems	Age at Onset	Condition Status	Remarks *(Such as, medications, special tests, x-rays, length of hospital stay, surgery and so on)*

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Health Information Form-*for Adults*

M. Medications

Note: Include all prescription medications, (such as nitroglycerin) over-the-counter medications (taken on a regular basis), vitamin supplements, and herbal remedies

Date	Medication / Dosage	Frequency

Health Information Form-*for Adults*

N. Doctor Visits

Date	Doctor	Reason	Diagnosis

Health Information Form-*for Adults*

O. Hospitalizations

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Admission Date	
Doctor		
Hospital		
Reason		Complications

Hospitalization Type (includes emergency room visits)		Diagnosis
Admission Date	Discharge Date	Admission Date
Doctor		
Hospital		
Reason		Complications

Health Information Form-*for Adults*

P. Surgeries

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Date	Doctor	Results
Hospital		
Surgical Procedure		
Description		Comments

Health Information Form-*for Adults*

Q. Lab or Imaging (Examples: X-ray, MRI, Mammogram)

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

Test Type	Date	Test Type	Date
Requesting Doctor	Administered by	Requesting Doctor	Administered by
Reason		Reason	
Result		Result	

R. Medical Devices (Examples: pacemaker, insulin pumas, breathing devices)

Device Type	Doctor	Device Type	Doctor
Hospital	Date	Hospital	Date
Reason		Reason	

Health Information Form-*for Adults*

S.Physical/Occupation Therapy

Therapy Type	Start Date	Stop Date	Frequency	Therapist

Health Information Form-*for Adults*

T. VISION

Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	
Date of Visit	Physician	Date of Visit	Physician
Vision RX		Vision RX	

U. Dental Health

Date of Visit	Dentist	Problems	Resolution

Making an Appointment-for your Health

This worksheet will help you know what to say and what to expect when making appointments with health care providers.

Fill in the blanks and **rehearse** at least once prior to calling.

You: Hi, my name is _____ _____(*first, last).*

I am calling to schedule an appointment with _____(*doctor/ clinician's name*) for/ to _____(*kind of service*).

Receptionist: Okay, what time/ day are you looking for?

You: I would like an appointment for _____(*month, day)* at _____ *(time)..*

Receptionist: Let me see if that time is open…Okay, I have you scheduled for _____ (*month, day*) at _____(*time*). Is that correct?

You: Yes, Thank you!

Receptionist: Okay, see you then!

If you have never been to this health care provider, they may ask you additional questions:

Receptionist: What is your date of birth?

You: _____ (*month, day, year*).

Receptionist: What is your current address?

You: _____(*address & zip code*)

Receptionist: What is the best number to reach you at?

You: _____ (*phone number)*

The receptionist may also ask you to arrive early to fill out paperwork.

GOOD LUCK!!

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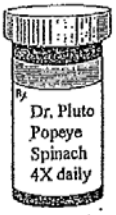
Individual Living Skills Module II

TAKING CARE OF YOURSELF



Prescription medicine is ordered by a doctor to treat a patient's specific condition. The label on the bottle or container will tell you how many times to take the medication each day. It will also have your name, your doctor's name, the date the prescription was filled as well as the expiration date, the name of the drug store and the prescription number. Other red, orange, or yellow labels may also be pasted to your prescription bottle. Read all labels carefully. The smaller labels will tell you about some possible side effects of the medication and specific directions about how to take the medicine.

Read the following medication labels. Describe in the box beneath each label where and how often you would take the medication as well as what possible side effects each medication might have or what precautions you would want to take.

XXX Pharmacy
555 Main St
Boston, Mass

Rx 000 Refills 0

Dr. XXXXXX

John Smith
1243 North St
Boston, MA

Take 1 capsule 3Xday
for 10 days.

MedicNAME
Orig. Date 6/1/95
Disc. After 6/1/95

FINISH ALL MEDICATION

TAKE WITH FOOD ONLY

XXX Pharmacy
555 Main St
Boston, Mass

Rx 001 Refills 0

Dr. XXXXXXX

John Smith
1243 North St
Boston MA

Take 1 Tablet every four hours for one week.

WARNING:
MAY MAKE YOU DROWSY.
DO NOT DRIVE AN AUTOMOBILE OR OPERATE HEAVY MACHINERY WHILE TAKING THIS MEDICATION.

NOT TO BE TAKEN WITH DAIRY PRODUCTS.

Independent Living Skills Module II

Remember to ask your doctor, nurse or pharmacist the following questions before you take any medication:

- Why do I need to take this medication?
- Are there any special instructions I should follow?
- What effects will the medication have on my body?
- Does this medication react with any other substances?
- How will I know if I am allergic to this medication? What are the symptoms of an allergic reaction?

If you think you have the symptoms of an allergic reaction, stop taking the medication immediately and call your doctor.

If there is no allergic reaction or any other complication, be sure to finish all the doses of medicine prescribed for you. Do this even if you feel better and you think you are "well" before you have completed the doses.

How Much Sleep Do You Need?

Sleep Cycles & Stages, Lack of Sleep, and Getting the Hours You Need

When you're scrambling to meet the demands of modern life, cutting back on sleep can seem like the only answer. How else are you going to get through your neverending to-do list or make time for a little fun? Sure, a solid eight hours sounds great, but who can afford to spend so much time sleeping? The truth is you can't afford not to.

Sleep consists of a series of distinct cycles and stages that restore and refresh your body and mind. Even minimal sleep loss takes a toll on your mood, energy, efficiency, and ability to handle stress. If you want to feel your best, stay healthy, and perform up to your potential, sleep is a necessity, not a luxury. Learn what happens when you're sleeping, how to determine your nightly sleep needs, and what you can do to bounce back from chronic sleep loss and get on a healthy sleep schedule.

The power of sleep

Many of us want to sleep as little as possible—or feel like we have to. There are so many things that seem more interesting or important than getting a few more hours of sleep. But just as exercise and nutrition are essential for optimal health and happiness, so is sleep. The quality of your sleep directly affects the quality of your waking life, including your mental sharpness, productivity, emotional balance, creativity, physical vitality, and even your weight. No other activity delivers so many benefits with so little effort!

Understanding sleep

Sleep isn't merely a time when your body and brain shut off. While you rest, your brain stays busy, overseeing a wide variety of biological maintenance tasks that keep you running in top condition and prepare you for the day ahead. Without enough hours of restorative sleep, you're like a car in need of an oil change. You won't be able to work, learn, create, and communicate at a level even close to your true potential. Regularly skimp on "service" and you're headed for a major mental and physical breakdown.

The good news is that you don't have to choose between health and productivity. As you start getting the sleep you need, your energy and efficiency will go up. In fact, you're likely to find that you actually get more done during the day than when you were skimping on shuteye.

How many hours of sleep do you need?

Average Sleep Needs Age	Hours
Newborns (0-2 months)	12 - 18
Infants (3 months to 1 year)	14 - 15
Toddlers (1 to 3 years)	12 - 14
Preschoolers (3 to 5 years)	11 - 13
School-aged children (5 to 12 years)	10 - 11
Teens and preteens (12 to 18 years)	8.5 - 10
Adults (18+)	7.5 - 9

According to the National Institutes of Health, the average adult sleeps less than 7 hours per night. In today's fast-paced society, 6 or 7 hours of sleep may sound pretty good. In reality, it's a recipe for chronic sleep deprivation. While sleep requirements vary slightly from person to person, **most healthy adults need between 7.5 to 9 hours of sleep per night to function at their best.** Children and teens need even more (*see box at right*). And despite the notion that sleep needs decrease with age, older people still need at least 7.5 to 8 hours of sleep. Since older adults often have trouble sleeping this long at night, daytime naps can help fill in the gap.

Sleep needs and peak performance

There is a big difference between the amount of sleep you can get by on and the amount you need to function optimally. Just because you're able to operate on 7 hours of sleep doesn't mean you wouldn't feel a lot better and get more done if you spent an extra hour or two in bed. The best way to figure out if you're meeting your sleep needs is to evaluate how you feel as you go about your day. If you're logging enough hours, you'll feel energetic and alert all day long, from the moment you wake up until your regular bedtime.

Think six hours of sleep is enough?

Think again. Researchers at the University of California, San Francisco discovered that some people have a gene that enables them to do well on 6 hours of sleep a night. But the gene is very rare, appearing in less than 3% of the population. For the other 97% of us, six hours doesn't come close to cutting it.

Signs and symptoms of sleep deprivation and lack of sleep

If you're getting less than eight hours of sleep each night, chances are you're sleep deprived. What's more, you probably have no idea just how much lack of sleep is affecting you.

How is it possible to be sleep deprived without knowing it? Most of the signs of sleep deprivation are much more subtle than falling face first into your dinner plate. Furthermore, if you've made a habit of skimping on sleep, you may not even remember what it feels like to be wide-awake, fully alert, and firing on all cylinders. It feels normal to get sleepy when you're in a boring meeting, struggle through the afternoon slump, or doze off after dinner. But the truth is that it's only "normal" if you're sleep deprived.

You may be sleep deprived if you...

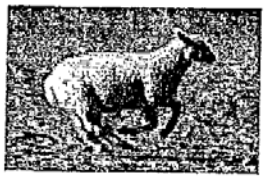
- Need an alarm clock in order to wake up on time
- Rely on the snooze button
- Have a hard time getting out of bed in the morning
- Feel sluggish in the afternoon
- Get sleepy in meetings, lectures, or warm rooms

- Get drowsy after heavy meals or when driving
- Need to nap to get through the day
- Fall asleep while watching TV or relaxing in the evening
- Feel the need to sleep in on weekends
- Fall asleep within five minutes of going to bed

While it may seem like losing sleep isn't such a big deal, sleep deprivation has a wide range of negative effects that go way beyond daytime drowsiness.

The effects of sleep deprivation and chronic lack of sleep

- Fatigue, lethargy, and lack of motivation
- Moodiness and irritability
- Reduced creativity and problem-solving skills
- Inability to cope with stress
- Reduced immunity; frequent colds and infections
- Concentration and memory problems
- Weight gain
- Impaired motor skills and increased risk of accidents
- Difficulty making decisions
- Increased risk of diabetes, heart disease, and other health problems



Is lack of sleep affecting your performance?

Lack of sleep affects your judgment, coordination, and reaction times. In fact, sleep deprivation can affect you just as much as being drunk. The BBC has a fun test to help you determine if lack of sleep is affecting your performance. Try the **Sheep Dash** test and see how well rested you *really* are. http://www.bbc.co.uk/science/humanbody/sleep/sheep/

Tips for getting good sleep, night after night

Do you feel like no matter how much you sleep, you still wake up exhausted? Learn how to maximize your sleep quality and sleep well every night by following a regular sleep-wake schedule, developing a relaxing bedtime routine, and improving your sleep environment. Read: Tips for Getting Better Sleep: How to Sleep Well Every Night @ http://www.helpguide.org/life/sleep_tips.htm

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Paying off your sleep debt

Sleep debt is the difference between the amount of sleep you need and the hours you actually get. Every time you sacrifice on sleep, you add to the debt. Eventually, the debt will have to be repaid. It won't go away on its own. If you lose an hour of sleep, you must make up that extra hour somewhere down the line in order to bring your "account" back into balance.

Sleeping in on the weekends isn't enough!

Many of us try to repay our sleep debt by sleeping in on the weekends. But as it turns out, bouncing back from chronic lack of sleep isn't that easy. One or two solid nights of sleep aren't enough to pay off a long-term debt. While extra sleep can give you a temporary boost (for example, you may feel great on Monday morning after a relaxing weekend), your performance and energy will drop back down as the day wears on.

Tips for getting and staying out of sleep debt

While you can't pay off sleep debt in a night or even a weekend, with a little effort and planning, you can get back on track.

- **Aim for at least 8 hours of sleep every night.** Make sure you don't fall farther in debt by blocking off a minimum of 8 hours for sleep each night. Consistency is the key.
- **Settle short-term sleep debt with an extra hour or two per night.** If you lost 10 hours of sleep, pay the debt back in nightly one or two-hour installments.
- **Keep a sleep diary.** Record when you go to bed, when you get up, your total hours of sleep, and how you feel during the day. As you keep track of your sleep, you'll discover your natural patterns and get to know your sleep needs. Click here to download Helpguide's sleep diary.
- **Take a sleep vacation to pay off a long-term sleep debt.** Pick a two-week period when you have a flexible schedule. Go to bed at the same time every night and allow yourself to sleep until you wake up naturally. No alarm clocks! If you continue to keep the same bedtime and wake up naturally, you'll eventually dig your way out of debt and arrive at the sleep schedule that's ideal for you.
- **Make sleep a priority.** Just as you schedule time for work and other commitments, you should schedule enough time for sleep. Instead of cutting back on sleep in order to tackle the rest of your daily tasks, put sleep at the top of your to-do list.

Independent Living Skills Module II

HEALTH INSURANCE

Taking good care of your health is very important. However, health care costs are rising steadily and the cost of medical care for a serious injury or illness can be extremely expensive if you are not covered by health insurance. Once you leave the Department's care, you will no longer be insured through Mass Health. You can reapply for coverage through your local Office of Transitional Assistance, but you have to be income eligible and certain other restrictions apply.

Most people obtain health insurance (coverage for ongoing and unexpected medical expenses) through their employers. Most often, you will be eligible for employee health insurance if you work full time.

Most employers require co-payments, depending on the type of coverage or insurance plan. In addition to those monthly co-payments, which range from $30 to $100, most insurance providers require co-payments for each doctor's visit and pharmacist's prescription. These usually range from $5 to $10 dollars. Emergency room co-payments have an average cost of $25.

Some employers offer dental insurance, again with co-payments required. Dental insurance often pays for 80% of needs, while you would be responsible for the remaining 20%.

Colleges will often offer basic health insurance to students, sometimes included in tuition. If you are planning to go to college, inquire about the specific details.

If you are not eligible for Mass Health, don't go to college, or don't work for full-time for one employer, private insurance is available through provider companies such as Blue

Independent Living Skills Module II

Cross/Blue Shield. This might be an option for you. Private insurance costs an average of $2500 a year, cover 80% of costs, and have deductibles (a certain amount of money you are required to pay before the insurance covers the rest).

You are aware by now that health insurance can be expensive. However, having no insurance is very risky and could end up being far more expensive than insurance.

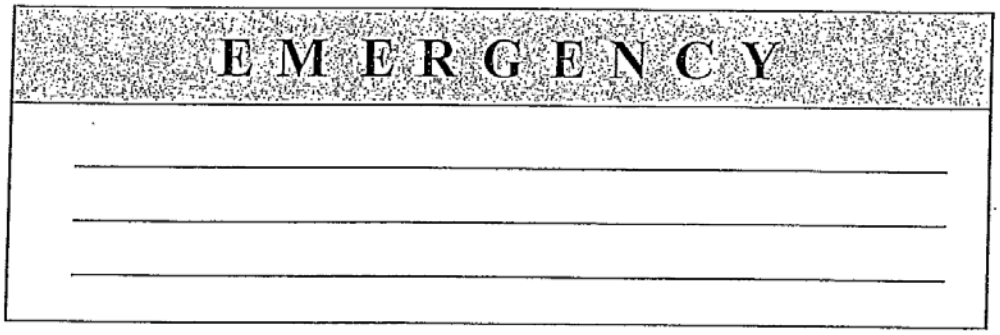
If none of the options listed above are viable possibilities for you at this time, you will have to pay for doctor's visits and health care facilities from your own pocket. Thankfully, many community health programs offer medical care services on a sliding fee basis. That means that the fee for services is based on your income. Some even provide free check-ups and emergency care in certain locations. However, these services are not available in all communities.

ACTIVITY

Research lower cost or free health care options in your community and list their location and phone numbers below.

Independent Living Skills Module II

Responding to medical emergencies quickly and efficiently could save your life. What kind of circumstances would lead you to immediately seek medical care at the emergency room of your local hospital?



Sometimes symptoms of illnesses might be mistakenly identified as harmless when they actually may indicate serious health problems. Therefore, it is important to always seek medical help if you have any questions. It is better to be safe than sorry.

For example, various cancers can have the following seven warning signals:

1) Change in bowel or bladder habits.
2) A sore that does not heal.
3) Unusual bleeding or discharge.
4) Thickening or lump in breast or elsewhere.
5) Indigestion or difficulty in swallowing.
6) Obvious change in a wart or mole.
7) Nagging cough or hoarseness.

If you have a warning signal or any medical concerns, see your doctor.