Grove City College Zerbe Health and Wellness Center
Report of Medical History Physical Exam and Immunizations

Last Name **First Name** **M. I.** **Birth date** **Sex**

Address

City **State** **Zip** **Home Phone**

E-mail **Student Cell Phone Number**

Father's Name **Occupation**

Street Address (if different from student's) **Email Address**

City **State** **Zip** **Best Phone Number**

Mother's Name **Occupation**

Street Address (if different from student's) **Email Address**

City **State** **Zip** **Best Phone Number**

Emergency Contact Name (other than parents) **Telephone** **Relationship**

Please contact Zerbe Health and Wellness Center via e-mail – gordonzc@gcc.edu if you have any questions regarding this form. If this form is not completed, you may be ineligible to register for classes. **Please mail completed health forms no later than August 1, 2024 to:** Zerbe Health and Wellness Center, 100 Campus Drive, Grove City College, Grove City, PA 16127.

Please do not fax or email health forms.

Health Information
(if none, please mark NA)

Medication allergies:

Food or other allergies:

Do you carry an Epi Pen? Y / N If yes, permission to notify Campus Safety? Y / N

Past hospitalizations/surgeries:

Daily medications:

Health situations you wish the health center to be aware of:

Significant family health history:

Student Personal History
(Answer Yes/No)

ADD/ADHD	EAR PROBLEM	SEIZURE DISORDER
ALCOHOL USE	EATING DISORDER	SICKLE CELL TRAIT
ANXIETY	FRACTURE (including stress)	SINGLE ORGAN OF PAIRED ORGANS
ARTHRITIS	GENETIC DISORDER	SPLEEN (SURGICAL REMOVAL)
ASTHMA	HEAD INJURY/CONCUSSION	SYNCOPE/FAINTING
CANCER	HEART MURMUR	THYROID DISEASE
CHEST PAIN	HEART PROBLEM	TOBACCO USE
CHICKEN POX	HEPATITIS	TROUBLE/VISION LOSS
DEPRESSION	HERNIA	OTHER
DIABETES	KIDNEY DISEASE	
DRUG USE	RECURRENT HEADACHES	

Physical Examination

Date of Physical _____ (preferred within 3 months prior to entrance; required no more than 1 yr.)

BP_____**P**_____**R**_____**Weight**_____**Height**_____ **LMP**_____

	Normal	Abnormal	Comments
SKIN			
EYES, HEAD, EARS, NOSE, THROAT			
RESPIRATORY			
CARDIOVASCULAR			
GASTROINTESTINAL			
HERNIA			
GENITOURINARY			
MUSCULOSKELETAL			
METABOLIC/ENDOCRINE			
NEUROLOGIC			
PSYCHIATRIC			
OTHER PHYSICAL ABNORMALITY OR DEFICIT			

Cleared for contact sports? _____**Yes** _____**No**

Comment(s): _____

Cleared for club/intramural sports? _____**Yes** _____**No**

Comment(s): _____

PLEASE NOTE: the NCAA requires first year (freshmen or transfer) varsity athletes to have sickle cell trait testing and to submit testing results to the athletics department. Please refer to the early summer communication from the athletic department on meeting this requirement. Proof of test results should be submitted electronically to the athletic department via the link on that correspondence from the Grove City Athletics by August 1. An athlete is not cleared to participate until this requirement is met per NCAA regulation.

Do you have any recommendations regarding the care of this student?

Provider Name: _____

Provider Address: _____

Telephone: _____

Signature/Title: _____

Please include a copy of your immunization records with your required health forms.

GROVE CITY COLLEGE MANDATORY IMMUNIZATIONS:

- M.M.R. (Measles, Mumps, Rubella): Two (2) doses
- Polio Series
- Varicella (Chicken Pox): Two (2) doses, or a history of chicken pox, or a positive varicella antibody
- Tetanus Diphtheria Pertussis: Primary series, Tdap booster within the last ten (10) years
- Meningococcal: Mandatory for all freshmen and transfers living in the residence halls. If student received this vaccine before their 16th birthday, a booster dose should be given for maximum protection. **Pennsylvania law requires a separate signed waiver if you will be living on campus and have not had this vaccine. (The waiver may be found using the same link as you received to retrieve required health forms.)**

GROVE CITY COLLEGE RECOMMENDED IMMUNIZATIONS:

- Hepatitis B Series
- Hepatitis A Series
- Influenza (annual)
- Meningitis B = The Advisory Committee on Immunization Practices (ACIP) currently recommends routine use of MenB vaccines among person aged >10 years who are at increased risk because of a serogroup B meningococcal disease outbreak. Adolescents and young adults aged 16-23 years may also be vaccinated with MenB vaccines to provide short-term protection against most strains of serogroup B meningococcal disease.
- Covid 19 – as per CDC recommendations

TUBERCULOSIS SCREENING

Tuberculosis Screening Questions (Required)

1. **Does the student have signs/symptoms of active tuberculosis disease? Yes ____ No ____**

   If **No**, proceed to 2. If **Yes,** obtain a QuantiFERON Gold (IGRA) test.

2. **Is the student a member of a high-risk group or is the student entering health science or education profession? Yes ____ No ____**

   If **No**, **stop**. If **Yes**, place tuberculin skin test. If there is a history of BCG vaccination obtain a QuantiFERON Gold (IGRA) test.

Tuberculin Skin Test (only required if symptomatic for disease or for health science or education majors):

Date/Time Administered: M _____ D _____ Y_____ ____:____ AM / PM

Administered by: _____

Date/Time Read: M _____ D _____ Y_____ ____:____ AM / PM

Read by: _____

Result: _____ mm (record result in actual mm induration)

Interpretation (based on mm of induration and risk factors): Positive _____ Negative _____

If the TB test is **positive** a QuantiFERON Gold (IGRA) must be done. Please attach results to this page.

If the QuantiFERON Gold (IGRA) is positive:

1. **Proof of a negative chest x-ray must be submitted prior to entrance.**
2. **Referral for treatment options must be completed prior to entrance.**

CONSENT FOR TREATMENT

The Zerbe Health and Wellness Center provides non-emergency health care services for students. Registered Nurses provide services during all hours the health center is open with physician services providing limited hours Monday through Friday while school is in session. Physician services are provided by Allegheny Health Network/Family Healthcare Partners in Grove City, PA.

I, (**student signs unless under 18 years of age, then parent signs**) consent to examination,

medical treatment, and care of_____by
Student Name

the Grove City College physicians and nursing staff at the Zerbe Health and Wellness Center at Grove City College. This may include a referral to AHN Grove City or other providers for assistance.

I permit Zerbe Health and Wellness Center staff to notify my parents or guardian in the Event of an emergency or serious illness.

Yes _____ No _____

I permit Zerbe Health and Wellness Center Staff to notify the Vice President and/or Executive Assistant of Student Life and Learning in the event of an emergency or serious illness.

Yes _____ No _____

I permit Zerbe Health and Wellness Center Staff to send me a text message.

Yes _____ No _____

Signature_____

Date _____

Signature of Legal Guardian Required if Student is a Minor (under 18)

Signature _____

Date_____Relationship_____

Witness_____Date_____

Health Insurance Information

PLEASE NOTE: This is separate from the insurance information you are required to submit online for Student Accounts. If you have any questions regarding Student Accounts' requirements, please contact them at **studentaccounts@gcc.edu.**

Insurance Company: _____
(or Health Care Sharing Ministry)

Insurance Company Phone: _____

Insurance Company Address: _____

Policy Number: _____

Group Number: _____

Name of Subscriber: _____

Subscriber's Employer: _____

Subscriber's Employer Address: _____

Relationship of Subscriber to Student: _____

Physician Name: _____

Physician Phone Number: _____

****You may also include a copy of your insurance card with these forms.**