

IMPORTANT INFORMATION

Dear Grove City College Student,

The staff at Zerbe Health and Wellness Center would like to take this opportunity to welcome you and to familiarize you with Health Center services and policies.

Below is a checklist of the required forms to be **mailed to and received by the Health Center no later than August 1, 2025**. **If you are a mid-year transfer, please refer to the deadline that was emailed to you.**

Required Health Form Checklist:

(all forms must be included and completed in full to meet requirements)

- _____ Page 1 – **General Student Contact Information**
- _____ Page 2 – **Health Information/Student Medical History**
- _____ Page 3 – **Physical Examination** (must be completed and signed by licensed medical professional)
- _____ Page 4 – **Immunization Record** (requirements noted on page 4)
- _____ Page 5 – **Tuberculosis Screening** (all students are required to answer both questions and proceed as stated on form)
- _____ Page 6 – **Consent for Treatment** (must be signed by parent/legal guardian if student is a minor)
- _____ Page 7 – **Health Insurance Information** (this is separate from what is required to be submitted online for Student Accounts)
- _____ **Meningitis Waiver, if declining vaccine**

Please note, routine physical exams are **not** done at the Health Center. Students participating in varsity athletics will have a pre-participation physical for their sport completed at the Health Center, but they **must** have all health forms noted above, **including** a physical exam (page 3) within the stated parameters, completed in full and received in the Health Center by the August 1 deadline to participate.

ALL REQUIRED HEALTH FORMS ARE DUE BY AUGUST 1, 2025. PLEASE MAIL TO:

Zerbe Health and Wellness Center
Grove City College
100 Campus Drive
Grove City, PA 16127

Forms may not be emailed, faxed, or dropped off.

FAILURE TO RETURN FORMS: Students who do not complete the required forms by the deadline will have a “hold” placed on their account, in which case they would not be permitted to register for classes, participate in athletics, access grades, or request transcripts.

QUESTIONS: The Health Center is closed for patient care from Commencement until the start of fall semester. If you have any questions regarding the health center or these forms, please email Mrs. Gordon at gordonzc@gcc.edu. You should expect a response within 48 hours.

SEMESTER HEALTH CENTER HOURS:

Monday through Friday: 8:00 AM - 5:00 PM
Saturday: 10:00 AM - 4:00 PM
Sunday: CLOSED

SEMESTER PHYSICIAN HOURS:

Monday through Friday beginning at 3:00/4:00 PM,
by appointment only until all present scheduled
patients are seen. Please call 724.458.3850 to schedule
an appointment.

In addition to physician services, students may see a nurse throughout the day, by appointment, to receive treatment for minor illnesses and injuries. Over the counter medications, hot and cold packs, crutches/other orthopedic supplies, and first aid/wound care supplies are available at no additional cost to the student.

It is mandatory that all entering students have a pre-admission physical examination completed and signed by a licensed medical professional. It is also required that all mandatory immunizations are up to date.

Under Pennsylvania law, students must receive vaccination against meningococcal disease if they wish to live in a residence hall. Students must provide written proof of having received the vaccine from their health care provider. If a student chooses to not receive the vaccine based on medical, religious, or other strong beliefs, a waiver must be signed. If the meningitis vaccine has already been given before the age of 16, a booster dose is recommended.

Consent for treatment is required for all students enrolled at the College to receive care at the Zerbe Health and Wellness Center. ***If you will be under the age of 18 when you begin the school year, your parent or legal guardian must sign the Consent for Treatment*** (page 6).

We would again like to welcome you to Grove City College and look forward to assisting you with your healthcare needs.

Please submit all required forms, in full, no later than August 1, 2025 unless otherwise specified.

Transfer students may obtain medical records from their previous school to submit along with our required forms.

Sincerely,

Zerbe Health and Wellness Center

Grove City College Zerbe Health and Wellness Center

Report of Medical History Physical Exam and Immunizations

Pages 1, 2, 5 (top 2 questions), 6, and 7 – completed by student or parent/legal guardian, if student is a minor

Page 3 and 5 (bottom section, if applicable) to be completed by student's health care professional

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

City	State	Zip	Home Phone
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E-mail	Student Cell Phone Number
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Father's Name	Occupation
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Street Address (if different from student's)	Email Address
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City	State	Zip	Best Phone Number
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Mother's Name	Occupation
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Street Address (if different from student's)	Email Address
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City	State	Zip	Best Phone Number
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Emergency Contact Name (other than parents)	Telephone	Relationship
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Please contact Zerbe Health and Wellness Center via e-mail at gordonzc@gcc.edu if you have any questions regarding these forms. Failure to complete and submit forms will result in a **hold** placed on student's account. Please mail completed health forms packet **no later than August 1, 2025** to: Zerbe Health & Wellness Center, 100 Campus Drive, Grove City College, Grove City, PA 16127. **If you are a mid-year transfer, please refer to the deadline emailed to you.**

Forms may not be emailed, faxed, or dropped off.

Health Information

(to be completed by student or parent/legal guardian (if student is a minor))

If **NONE**, please write **NA**

Medication allergies and reaction:

Food or other allergies and reaction:

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

Past hospitalizations/surgeries:

Daily medications and dosage:

Significant family health history:

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

Student Personal History

(Check **Yes** or **No** to each)

	Y	N		Y	N		Y	N
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					

(NOTE: We kindly ask, with any major change in medical history, student would provide Zerbe Health Center staff timely notification.)

Physical Examination (to be completed by health care professional)

Student's Name _____

Date of Physical _____ (**preferred** within 3 months of semester start; **required** no more than one year prior to the start of semester)

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 Dept. on meeting this requirement. Proof of test results must be **submitted electronically** to them via the link included in their correspondence **no later than August 1**. An athlete is **not** cleared to participate until this requirement is met per NCAA regulations.

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.

Your physician's office should have a copy of your most recent immunization records.

GROVE CITY COLLEGE MANDATORY IMMUNIZATIONS:

- M.M.R. (Measles, Mumps, Rubella): Two (2) doses
- Polio Series – Four (4) doses – 4th dose not necessary if 3rd dose given at or after age 4 and at least 6 months after previous dose given.
- Varicella (Chicken Pox): Two (2) doses, or a history of chicken pox, or a positive varicella antibody
- Tetanus, Diphtheria, and Pertussis: Four (4) doses ; one dose at or after age 4; 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. **A separate waiver (see online waiver) is required if you will be living on campus and have not received the meningococcal vaccine.**

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

Student's Name _____

Tuberculosis Screening Questions (**Questions 1 and 2 are required for all students to answer**):

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** to both questions, **STOP**. If **Yes**, place tuberculin skin test. If there is a history of BCG vaccination obtain a ***QuantIFERON Gold (IGRA) test**.

Tuberculin Skin Test:

Facility where administered: _____

Date/Time Administered: M _____ D _____ Y _____ : _____ AM / PM

Administered by: _____ (print) _____ (signature) _____ (title)

Date/Time Read: M _____ D _____ Y _____ : _____ AM / PM

Read by: _____ (print) _____ (signature) _____ (title)

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 or advanced practice provider (APP) services available for limited hours Monday through Friday while school is in session. Physician and APP services are provided by Allegheny Health Network/Family Healthcare Partners in Grove City, PA and the surrounding area.

I, **(student signs unless under 18 years of age, then parent/legal guardian signs)** consent to examination, medical treatment, and care of _____ by the
(student's name)

Grove City College physicians and nursing staff at 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 legal 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 _____

I am aware emergency medical treatment and/or transfer to another medical facility may be necessary upon assessment by the nurse, physician, or APP.

Student Signature (if age 18 or older) _____

Date _____

Signature of Parent/Legal Guardian required if student is a minor (under age 18):

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.**