Name: _____

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 – aepagano@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 to: Zerbe Health and Wellness Center, 100 Campus Drive, Grove City College, Grove City, PA 16127. **Please do not fax or email health forms.**

Revised
April 2020

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Health Insurance Information

As a matter of College policy, all full-time students (12 credits or more) must annually demonstrate health insurance coverage in order to attend Grove City College. For those students not covered under an alternative insurance plan (via a parent, guardian, etc.) the College has partnered with United Healthcare to offer a Student Injury and Sickness Policy at an annual cost of $1,740 for the 2020-2021 plan year. Coverage under this plan runs from August 15th, 2020 to August 14th, 2020

Complete the section below to return with your Physical Forms. Then, submit online either your health insurance information or your selection to purchase the College plan using the following steps:

- Login to the myGCC portal at https://my.gcc.edu/ics (must be logged in as student, not parent)
- Go to "Financial Info"
- Open the "Health Insurance" portlet by clicking on the title
- Make your selection to either purchase the College plan or enter your current, valid health insurance information that you have noted below.

____ I do not have health insurance coverage and will select to purchase the College Plan. I understand that my student account will be charged for the cost of the plan and that payment is due with my fall semester charges on August 1st.

____ I currently have the following health insurance coverage and will submit it in order to waive purchasing the College Plan:

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 but that is not a substitute for submitting your information online via myGCC. Students not submitting their health insurance selection online by June 15th each year will be automatically charged the full cost of the College plan on their student account. This charge will be refunded within 2 business days if the student submits their health

Name: _____

insurance information prior to September 1st. After this date, the student will be officially enrolled in the College plan and the fee will be non-refundable.**

Health Information
(if none, please mark NA)

MEDICATION ALLERGIES:

FOOD OR OTHER ALLERGIES:

PAST HOSPITALIZATIONS/SURGERIES:

DAILY MEDICATIONS:

HEALTH SITUATIONS YOU WISH THE HEALTH CENTER TO BE AWARE

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
ARTHRITIES	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	

Name: _____

Physical Examination

Date of Physical_____ (done within 3 months prior to entrance)

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: _____

CLEARED FOR CLUB/INTRAMUAL SPORTS? _____YES _____NO
Comment: _____

IF STUDENT PLANS TO PARTICIPATE IN VARSITY ATHLETICS PLEASE SEE SEPARATE FORM REGARDING SICKLE CELL TRAIT

DO YOU HAVE ANY RECOMMENDATIONS REGARDING THE CARE OF THIS STUDENT?

Provider
Name_____
Provider Address_____

Telephone _____
Signature/Title_____

Name: _____

PLEASE ATTACH IMMUNIZATION RECORD TO THIS HEALTH FORM

GROVE CITY COLLEGE MANDATORY IMMUNIZATIONS:

- M.M.R. (Measles, Mumps, Rubella): two doses
- Polio series
- Varicella (chicken pox): **two doses**, or a history of chicken pox, or a positive varicella antibody.
- Tetanus Diptheria Pertussis: primary series, Tdap booster within last 10 years
- Meningococcal: Mandatory for all freshman 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.**

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 persons aged ≥10 years who are at increased risk for serogroup B meningococcal disease, and persons identified to be 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.

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TUBERCULOSIS SCREENING

I. TUBERCULOSIS SCREENING (Required)

1. **Does the student have signs/symptoms of active tuberculosis disease? Yes_____ No_____**

If **No**, proceed to 2. If **Yes**, proceed with additional evaluation to exclude active tuberculosis disease including turberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. **Is the student a member of a high risk group or is the student entering the health science or education professions? Yes_____ No_____**

If **No**, stop. If **Yes,** place tuberculin skin test. A history of BCG vaccination should not preclude testing of a member of a high-risk group**.**

3. **Tuberculin Skin Test: Date Given M____D____Y____**
   Date & Time: _____
   Administered by: _____
   Date Read M____D____Y____
   Read by _____
   Result: _____mm (record result in actual mm induration)
   Interpretation: (based on mm of induration and risk factors)
   Positive_____ Negative_____
4. **Chest X-Ray** (required if the tuberculin skin test is positive)
   Date of chest x-ray M____ D____Y____
   Result: Normal_____ Abnormal_____

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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 UPMC/ 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 Grove City Medical Center 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_____