



## **Health Insurance Information**

**Insurance Company** \_\_\_\_\_

**Subscriber Name** \_\_\_\_\_

**Relationship to Student** \_\_\_\_\_

**Policy Number** \_\_\_\_\_ **Group Number** \_\_\_\_\_

**Insurance Address** \_\_\_\_\_

**Insurance Telephone  
Number** \_\_\_\_\_

**Physician Name** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

## **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

## Family History

| Relationship | Age   | State of Health | Chronic illness, or<br>if deceased, cause |
|--------------|-------|-----------------|---|
| Mother       | _____ | _____           | _____                                     |
| Father       | _____ | _____           | _____                                     |
| Brother(s)   | _____ | _____           | _____                                     |
|              | _____ | _____           | _____                                     |
|              | _____ | _____           | _____                                     |
|              | _____ | _____           | _____                                     |
| Sister(s)    | _____ | _____           | _____                                     |
|              | _____ | _____           | _____                                     |
|              | _____ | _____           | _____                                     |
|              | _____ | _____           | _____                                     |

## Personal History

(Please indicate all that apply, explain positives below)

|                   |                                |                                   |                                 |
|-------------------|--------------------------------|-----------------------------------|---------------------------------|
| ABNORMAL BLEEDING | DIABETES                       | RHEUMATIC FEVER                   | SPLEEN<br>(SURGICAL<br>REMOVAL) |
| ANEMIA            | SINUS TROUBLE                  | HIGH BLOOD<br>PRESSURE            | HERNIA                          |
| ARTHRITIS         | EAR<br>TROUBLE/HEARING<br>LOSS | HIGH CHOLESTEROL                  | ANXIETY                         |
| ASTHMA            | EYE<br>TROUBLE/VISION<br>LOSS  | THYROID DISEASE                   | DEPRESSION                      |
| CANCER            | FRACTURE<br>(INCLUDING STRESS) | HEPATITIS                         | ADD/ADHD                        |
| HEAT OR SUNSTROKE | JOINT SPRAIN OR<br>DISLOCATION | INTENSTINAL OR<br>STOMACH TROUBLE | EATING<br>DISORDER              |
| CHICKEN POX       | SCOLOIOSIS                     | KIDNEY DISEASE                    | TOBACCO<br>USE                  |
| HEAD INJURY       | HEART MURMUR                   | SINGLE ORGAN OF<br>PAIRED ORGANS  | ALCOHOL<br>USE                  |
| GENETIC DISORDER  | CHEST PAIN                     | DISABILITY                        | DRUG USE                        |
| SICKLE CELL TRAIT | SYNCOPE/FAINTING               | MONONUCLEOSIS                     | OTHER                           |
| SEIZURE DISORDER  | HEART PROBLEM                  | RECURRENT<br>HEADACHES            |                                 |
|                   |                                |                                   |                                 |

## Physical Examination

Date of Physical \_\_\_\_\_ (done within 3 months prior to entrance)

BP \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ LMP \_\_\_\_\_

|                                       | Normal | Abnormal | Comments |
|---------------------------------------|--------|----------|----------|
| SKIN, BLOOD                           |        |          |          |
| 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/INTRAMURAL SPORTS?**    \_\_\_\_\_ YES    \_\_\_\_\_ NO

Comment: \_\_\_\_\_

To the physician: All students are required to participate in the Grove City College Fitness and Wellness Course. This course includes a comprehensive fitness appraisal, and emphasizes overall physical fitness. The course includes aerobic endurance, and muscular strength and flexibility training.

Clearance to participate in the physical activity portion of the Fitness and Wellness Course

\_\_\_\_\_ Yes    \_\_\_\_\_ No

\_\_\_\_\_ Yes with restrictions or modifications as specified \_\_\_\_\_

**DO YOU HAVE ANY RECOMMENDATIONS REGARDING THE CARE OF THIS STUDENT?**    \_\_\_\_\_ YES    \_\_\_\_\_ NO

IF YES SPECIFY \_\_\_\_\_

**Provider**

**Name** \_\_\_\_\_

**Provider Address** \_\_\_\_\_

Telephone and Fax \_\_\_\_\_

**Signature/Title** \_\_\_\_\_

## Immunization Record

### TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

- A. M.M.R.** (Measles, Mumps, Rubella) two doses required if born after 1956
1. Dose 1 given at age 12 months or later M \_\_\_ D \_\_\_ Y \_\_\_
  2. Dose 2 given at least 28 days after first dose M \_\_\_ D \_\_\_ Y \_\_\_
- B. POLIO** (Primary series, doses at least 28 days apart. Three primary series are acceptable)
1. **OPV alone** (oral Sabin 3 doses)  
#1 M \_\_\_ D \_\_\_ Y \_\_\_ #2 M \_\_\_ D \_\_\_ Y \_\_\_ #3 M \_\_\_ D \_\_\_ Y \_\_\_
  2. **IPV/OPV sequential**  
#1 M \_\_\_ D \_\_\_ Y \_\_\_ #2 M \_\_\_ D \_\_\_ Y \_\_\_ #3 M \_\_\_ D \_\_\_ Y \_\_\_
  3. **IPV alone** (injected Salk four doses)  
#1 M \_\_\_ D \_\_\_ Y \_\_\_ #2 M \_\_\_ D \_\_\_ Y \_\_\_ #3M \_\_\_ D \_\_\_ Y \_\_\_
- C. VARICELLA** (Birth in US before 1980, a history of chicken pox, a positive Varicella antibody or two doses of vaccine meets the requirement.)
1. **History of Disease** Y N (or) **Birth in U.S. before 1980** Y N
  2. **Varicella Antibody** M \_\_\_ D \_\_\_ Y \_\_\_ **Reactive** \_\_\_ **Non-reactive** \_\_\_
  3. **Dose #1** M \_\_\_ D \_\_\_ Y \_\_\_ **Dose #2** M \_\_\_ D \_\_\_ Y \_\_\_  
Dose #2 given at least 12 weeks after first dose age 1-12, and at least 4 weeks after first dose if age 13 years or older.
- D. TETANUS-DIPHTHERIA-PERTUSSUS** (Primary series with DTaP, DTP, or Td, and booster with Td and Tdap in the last 10 years.)
1. **Primary series dose #1** M \_\_\_ D \_\_\_ Y \_\_\_ **#2** M \_\_\_ D \_\_\_ Y \_\_\_  
**#3** M \_\_\_ D \_\_\_ Y \_\_\_ **#4** M \_\_\_ D \_\_\_ Y \_\_\_
  2. **Booster Tdap (preferred) at least 2 to 5 years since last Td** M \_\_\_ Y \_\_\_
  3. **Booster Td within last 10 years** M \_\_\_ D \_\_\_ Y \_\_\_
- E. MENINGOCOCCAL** (mandatory for all freshmen and transfers living in dormitory or residence hall)
1. **Conjugate** (preferred) M \_\_\_ D \_\_\_ Y \_\_\_
  2. **Polysaccharide** (acceptable alternative) M \_\_\_ Y \_\_\_ D \_\_\_

**PLEASE NOTE: THE ABOVE IMMUNIZATIONS ARE MANDATORY  
ADMISSION REQUIREMENTS**

**IMMUNIZATION RECORD CONTINUED**

**F. HEPATITIS B** (Recommended. Three doses of vaccine or a positive hepatitis surface antibody meets the requirement.)

1. Dose #1 M\_\_\_\_Y\_\_\_\_ Dose#2 M\_\_\_\_Y\_\_\_\_ Dose#3 M\_\_\_\_Y\_\_\_\_

2. Hepatitis B surface antibody M\_\_\_\_Y\_\_\_\_

Result: Reactive\_\_\_\_ Non-reactive\_\_\_\_

**G. HEPATITIS A** (not required)

1. Hepatitis A Dose #1 M\_\_\_\_D\_\_\_\_Y\_\_\_\_ #2 M\_\_\_\_D\_\_\_\_Y\_\_\_\_

**H. INFLUENZA** (Recommended. Annual immunization recommended if Vaccine available to avoid disruption of academic activities.)

Date: M\_\_\_\_Y\_\_\_\_ M\_\_\_\_Y\_\_\_\_ M\_\_\_\_Y\_\_\_\_ M\_\_\_\_Y\_\_\_\_

**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 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\_\_\_\_

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\_\_\_\_

**HEALTH CARE PROVIDER**

Name\_\_\_\_\_ Address\_\_\_\_\_

Signature\_\_\_\_\_ Phone\_\_\_\_\_

## 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 Family Healthcare Partners in Grove City, PA.

I, \_\_\_\_\_, consent to examination, medical treatment, and care of \_\_\_\_\_ by 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 Assistant Dean of Students and/or the Vice President of Student life and Learning in the event of an emergency or serious illness.

Yes \_\_\_\_\_ No \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### **Signature of Legal Guardian Required if Student is a Minor**

Signature \_\_\_\_\_

Date \_\_\_\_\_ Relationship \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_