

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