GROVE CITY COLLEGE

**IMPORTANT INFORMATION -Please use checklist to assist with complete submission of forms via US Mail.**

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, 2026**. **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, 2026. 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.

**SCHEDULING APPOINTMENTS:** Appointments are pre-scheduled. Please call 724.458.3850 or email gordonzc@gcc.edu to schedule an appointment.

**ZERBE HEALTH CENTER HOURS:**
(Nursing-available fall and spring semesters)

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

**ZERBE PHYSICIAN/APP HOURS:**
(Providers – available fall and spring semesters)

Monday through Friday beginning at 3:00/4:00 PM, **by appointment only** until all present scheduled patients are seen.

In addition to physician/APP 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. If booster not received, a signed waiver is required as well.

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, 2026 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**

**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 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, 2026 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.**

GROVE CITY COLLEGE

# Health Information

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

**If NONE, please write NA**

**Medication/Food/other known allergies:**

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

**Past hospitalizations/surgeries with dates: (Note: if surgery occurred within last 2 years, attach Surgeon**

**Clearance for activity/sports)**

**Medications -Name, dosage and how often taken:**

**Significant family health history:**

**Health situations or additional health information 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 ONLY**. **DO NOT SEND TO THE HEALTH CENTER!**Proof of test results must be **submitted electronically** to the Athletic Department as instructed in emailed corrspondence from your coach or the athletic director. 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:** _____

GROVE CITY COLLEGE

**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 (MCV): 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.**

https://www.pa.gov/content/dam/copapwp-pagov/en/health/documents/topics/documents/school-health/SIR8.pdf
https://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/028/chapter23/s23.83.html&d=reduce

## GROVE CITY COLLEGE RECOMMENDED IMMUNIZATIONS:

- Hepatitis A Series
- Hepatitis B Series: Three (3) properly-spaced doses of hepatitis B vaccine, unless a child receives a vaccine as approved by the United States Food and Drug Administration for a two-dose regimen, or a history of hepatitis B immunity proved by laboratory testing. Hepatitis B vaccine may be administered as single antigen vaccine or in a combination form.
- 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

https://www.immunize.org/official-guidance/state-policies/vaccine-requirements/hepb-college-2024/

GROVE CITY COLLEGE

**TUBERCULOSIS SCREENING**

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

**Student's Name** _____

**ALL STUDENTS are required to answer the following questions and proceed as directed):**

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 the nursing 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.**

---

**ZERBE HEALTH CENTER USE ONLY**

Grove City College Zerbe Health Center Staff Signature: _____

GROVE CITY COLLEGE

# 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 Signature _____ Date _____
Print Name _____

GROVE CITY COLLEGE

# 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: _____

****Include a copy of your insurance card (front and back) with these forms.**