Admission Requirements

The health and wellness of Grinnell College students is of utmost importance. Therefore, all first year students are required to complete an online health history, a signed consent for treatment form, show proof of the required immunization, have a physical examination and provide proof of health insurance.

All first year students MUST complete the required health forms and submit them to Student Health and Counseling Services (SHACS) by July 15th. They will not able to register for classes until all forms and immunization requirements are submitted and complete.

Some of the forms will be completed online; others will be downloaded, filled out and mailed to SHACS.

The forms may be accessed at: http://shacs.com.grinnell.edu/

- **Consent for Treatment Form** – signed and submitted online.
- **Immunization history form** – All sections that apply should be completed online.
- **Medical Providers Health Form** – This form is downloaded and taken to the student’s physician for their health physical. This form is then mailed to SHACS.
- **Consent for treatment of a minor** – If the student will be under the age of 18 when they arrive on campus, this form should be downloaded, signed by the student’s parent or legal guardian and mailed to SHACS.
- **Student health history form** – This form is to be completed online.
- **Tuberculosis screening form** – The student should answer all five questions online. *If they answer yes to any of these questions, the TB evaluation form should be downloaded and taken to the student’s physician to complete.* This form should be mailed to SHACS.

- **Insurance cards**: All students are required to have health insurance while attending Grinnell. It may be through their existing parental or personal policy and/or the student may purchase the College’s student group insurance. It is required that the insurance card be scanned into the SHACS registration system. The student should bring their insurance card(s) to campus with them in order to complete this requirement.

- **Athletes** – Athletes will be required to submit forms to the Athletic Department and to SHACS. *The athlete should make sure that SHACS receives their health physical form.* SHACS will then provide a copy to Athletics so the athlete may participate in their sport.
**Immunizations REQUIRED**

Measles/Mumps/Rubella

- Must have two MMRs

Tetanus/Diphtheria/Tdap:

- Must be within 10 years

Meningococcal

- Must be within the last 5 years

Chicken Pox/Varicella

- Either immunization or date of disease

Tuberculin Skin Test

- The online TB Evaluation/Screening Form should be completed to determine if the student will need a TB skin test. If the answer is yes, the form should be downloaded for their physician to complete.

**Immunizations RECOMMENDED**

Hepatitis B

Gardasil/HPV

Hepatitis A

___________________________           _________________________
Medical Advisor                 Director of Health Service          Date
# Student Health Record

## PHYSICIAN’S REPORT OF HEALTH EVALUATION

**To the Examining Physician:** Please review the student’s report and complete this physician’s form. No other form will be accepted. **We ask that you complete the immunization section and provide a copy of the student’s immunization record for verification.** This form must be signed and dated to be accepted. Since this student has already been accepted for admission, the information supplied will not affect his or her status and will be used only as background for providing any needed care by Student Health and Counseling Services and/or Athletics. This information will not be released to any requesting party without the student’s written consent. **This form, along with a copy of the student’s immunization record, should be given to the student who will return it to the College.**

### Name

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
</tr>
</thead>
</table>

### Date of Birth ___________ (month/day/year)

### Sex □ Female □ Male □ Intersex □ MTF Female □ FtM Male

### Pronouns Used: □ she/her/hers □ he/him/his □ they/them/theirs

### Blood Pressure ___________

### Weight ___________ pounds □ Height ___________ inches

### Hemoglobin (if indicated) ___________ Gms.

### Are there any abnormalities of the following systems?

<table>
<thead>
<tr>
<th>Head, Ears, Nose, or Throat</th>
<th>Yes</th>
<th>No</th>
<th>Describe fully</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Cardiovascular</td>
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<tr>
<td>Hernia</td>
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<td></td>
<td></td>
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<tr>
<td>Eyes</td>
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<td></td>
</tr>
<tr>
<td>Genitourinary</td>
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<td>Musculoskeletal</td>
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<tr>
<td>Metabolic/Endocrine</td>
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<tr>
<td>Neuropsychiatric</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Is the patient under the care of a medical specialist for any medical condition? □ Yes □ No

If so, what? ___________________________

### Is the patient now under treatment for any psychological condition? □ Yes □ No

Diagnosis ___________________________

### Do you have any recommendations regarding the care of this patient? □ Yes □ No

__________

### Recommendations for physical activity/athletics: □ Unlimited □ Limited

Explanation ___________________________

### Physician’s Signature ___________________________

### Printed Physician’s name ___________________________

### Practice Name ___________________________

### Practice Address/Phone Number ___________________________

### Date ___________________________

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**Medications (please list below)** □ None

______________________________

______________________________

______________________________

**Allergies (please list below)** □ None Known

______________________________

______________________________

______________________________

**REQUIRED Immunizations**

**Measles/Mumps/Rubella Dates**

(Must have two MMRs)

Dose #1 [month/day/year] ___________

Dose #2 [month/day/year] ___________

**Tetanus/Diphtheria/Tdap**

□ TT □ TD □ Tdap

(Must be within 10 years) Date ___________

**Meningococcal**

□ Menactra □ Menevo □ MenACWY

(Must be within 5 years) Date ___________

(MenB see recommended immunizations)

**Chicken Pox/Varicella**

Dose #1 (month/day/year) ___________

Dose #2 (month/day/year) ___________

If you had the chicken pox disease, physician to verify Date of disease ___________

**Tuberculin Skin Test**

Complete the online TB Evaluation/Screening Form to determine if you will need a TB skin test. If the answer is yes, download that form and have physician complete.

**RECOMMENDED Immunizations**

**MenB** Date ___________

**Hepatitis B**

First Second Third

**Gardasil/HPV**

First Second Third

**Hepatitis A**

First Second