WEST LIBERTY UNIVERSITY

Return completed forms to:
West Liberty University
Department of Health Services
208 University Drive
College Union Box 127
West Liberty, WV 26074-0295
Or Fax: 304-336-8315

CONFIDENTIAL MANDATORY HEALTH FORM

This certificate of health must be completed and returned to the university. Failure to submit this form may result in being denied treatment at the Health Service, participation in intercollegiate sports, or entry into some academic programs. Please print or type all entries.

Name: ___________________________________ ________________ ______ Student ID No: ____________________
Last First MI

Semester Entering: ☐ Fall ☐ Spring ☐ Summer Year_______ Status: ☐ Freshman ☐ Transfer ☐ Return

Date of Birth: _____________________ Gender: ☐ Male ☐ Female Marital Status: ☐ S ☐ M Cell Phone____________

Home Address: ____
Street City State Zip Code

Person to notify in emergency: ____ Relationship: ______________________

Address, if different from above: ____

Emergency Contact Phone Number: Work_______________________________ Home_______________________________

Medical Insurance Company: ____ Policy No.: ______________________

Does this insurance cover injuries sustained if student participates in athletics? ☐ Yes ☐ No
Enclose a photocopy of your insurance card, front and back.

Proof of insurance is required for students entering the Athletic Training Education Program (ATEP) and Nursing Program

Section I: Health History

A. Are you allergic to medications? ☐ **Yes** ☐ **No** Describe____

____

Do you have any other allergies? ☐ **Yes** ☐ **No** Describe____

B. Do you take any medications regularly? ☐ **Yes** ☐ **No** If yes, please list them._____________________________

____

C. Medical History: Check all that apply to you –past or present.

☐ High Blood Pressure	☐ Asthma	☐ Hepatitis or jaundice	☐ Headaches
☐ Heart Disease	☐ Bronchitis	☐ Gall Bladder disease	☐ Arthritis
☐ Heart Murmur	☐ Pneumonia	☐ Colitis	☐ Low back pain
☐ Mitral Valve Prolapse	☐ Tuberculosis	☐ Cancer	☐ Skin diseases
☐ Rheumatic Heart Disease	☐ Indigestion	☐ Diabetes	☐ Blood disorders
☐ Need dental premedication	☐ Constipation	☐ Thyroid Disease	☐ Sexually Transmitted Disease
☐ Chest pain/tightness	☐ Hemorrhoids	☐ Kidney disease	☐ Anxiety/ Depression
☐ Shortness of Breath	☐ Ulcers	☐ Gout	☐ Alcohol/Drug Abuse

D. Do you have any significant, on-going health problems or concerns of which you want the WLU Health Service to be aware? ☐ **Yes** ☐ **No** If yes, please explain:____

E. Will you be entering: ☐ **Athletic Training** ☐ **Dental Hygiene** ☐ **Exercise Physiology** ☐ **Nursing**
I give my permission to the West Liberty University Health Service to provide a copy of this Mandatory Health Form to the program marked above as required by that program. ☐ **Yes** ☐ **No**

F. Will you be participating in intercollegiate sports? ☐ **Yes** ☐ **No** If yes, what sport(s)? _________________
I give my permission to the WLU Health Service to share this Mandatory Health form with the program marked above so that I may participate. ☐ **Yes** ☐ **No**

G. I give my permission to the West Liberty University Health Service to provide a copy of my immunization record with the Office of Admissions to meet the requirements for my admission to West Liberty University by the State of West Virginia. ☐ **Yes** ☐ **No**

STUDENT SIGNATURE REQUIRED

Signature of Student ____ **Date** _________________

Section II: PARENT/GUARDIAN SIGNATURE REQUIRED IF STUDENT IS UNDER 18 YEARS OF AGE.

Medical consent if under 18 years of age

I authorize the WLU Health Service and the WLU Counseling Center to employ diagnostic procedures and to render any treatment or medical, surgical, psychological, or psychiatric care deemed necessary to the health and well being of my child.

In case of an emergency, I grant the following people permission to sign any and all necessary medical forms on my behalf: Dean of Enrollment and Student Services, WLU Health Service Staff, Director of Housing and Residence Life, and Residence Life Area Coordinators. It is understood that the above designated officials of West Liberty University are in no way financially responsible or liable for any or all medical care, treatment, or surgery performed.

I grant permission for the transfer of my child to an accredited hospital or other care facility if deemed necessary by the medical or mental health provider.

I agree to be responsible for any expense in connection with the aforesaid, where my insurance does not provide payment of the same.

I grant permission for the hospital or other care facility to provide information concerning my child's treatment by their facility to the West Liberty University Health Service or the West Liberty University Counseling Center for continuity of care.

____ ___________________________________
Signature of Parent or Legal Guardian (if applicable) **Date**

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WLU Health Service
CONFIDENTIAL MANDATORY HEALTH FORM (Cont.)

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

Name ____ Student ID No: ____________________
Last First MI

Section III: IMMUNIZATIONS

■REQUIRED FOR ALL FULL TIME STUDENTS:

A. M.M.R. (Measles, Mumps, Rubella)

1. Dose 1 given at age 12-15 months or later . . .. #1 ____/____ (M Y)
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose. . . . . #2 ____/____ (M Y)

■REQUIRED FOR ATHLETIC TRAINING, DENTAL HYGIENE, EXERCISE PHYSIOLOGY and NURSING (B, C, D)

B. HEPATITIS B

1. Dose #1 ____/____ (M Y) Dose #2 ____/____ (M Y) Dose #3 ____/____ (M Y)
2. Hepatitis B surface antibody Date ____/____ (M Y) Result: ☐ Reactive ☐ Non-reactive

C. TUBERCULOSIS SCREENING

1. PPD Tuberculin Skin Test:
   Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)
   Result: ________ mm of induration Interpretation: ☐ Positive ☐ Negative
2. Chest x-ray (required if PPD test is positive) Result: ☐ Normal ☐ Abnormal Date of x-ray: ____/____/____ (M D Y)

D. VARICELLA

1. History of Disease: ☐ Yes ☐ No
2. Varicella antibody ____/____ (M Y) Reactive _______ Non-reactive ______
3. Immunization: Dose #1 ___/____ (M Y) #2 ____/____ (M Y)

■HIGHLY RECOMMENDED (B through G):

E. TETANUS-DIPHTHERIA -PERTUSSIS

1. Primary series of four doses with DTaP or DTP:
   #1 ____/____ (M Y) #2 ____/____ (M Y) #3 ____/____ (M Y) #4 ____/____ (M Y)
2. Tetanus-Diphtheria-Pertussis (Tdap) booster within the last ten years . . . . ____/____ (M Y)

F. MENINGOCOCCAL (One dose — received after the age of 16 but preferably at entry into college for freshmen living in residence halls.)

Tetravalent conjugate vaccine **(Menactra®), preferred** Date ____/____ (M Y) **OR**

Tetravalent polysaccharide vaccine **(Menamune®)** Date ____/____ (M Y)

G. POLIO (OPV/IPV)

1. OPV alone (oral Sabin three doses): #1___/___/___ #2 ___/___/___ #3___/___/____ OR
2. IPV alone (injected Salk four doses): #1___/___/___ #2 ___/___/___ #3___/___/____ #4___/___/____

Health Care Provider's Signature ____Date________________

(Required for verification of immunizations)

Revised: 02/2013

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Section IV: PHYSICAL EXAMINATION

(THIS SECTION TO BE COMPLETED BY YOUR PHYSICIAN, NURSE PRACTITIONER OR PHYSICIAN'S ASSISTANT)

Height _______ Weight _______ Blood Pressure _______ Pulse _______ Respiration _______

Eyes Glasses: ☐ Yes ☐ No Contact Lenses: ☐ Yes ☐ No

Normal		Abnormal	Notes on Abnormalities
_____	Skin	______	
_____	Hearing	______	
_____	Head	______	
_____	Ear, Nose & Throat	______	
_____	Neck: Thyroid	______	
_____	Cardio-vascular	______	
_____	Lungs	______	
_____	Breasts	______	
_____	Abdomen	______	
_____	Rectum	______	
_____	Genitalia	______	
_____	Menstruation	______	
_____	Back & Extremities	______	
_____	Reflexes	______	

If student participates in intercollegiate activities, what sport(s)? ________________________________

Recommendations for physical activity (PE, intramurals, sports) ☐ **Unlimited** ☐ **Limited** **Explain**.

Please list current medications: ____

Please note allergies or sensitivities. ____

Does the student require a special diet? ☐ Yes ☐ No Explain: ________________________________

Is this student presently under medical therapy or psychological counseling? ____________________________

Explain any physical or emotional conditions, which you consider important. ____________________________

____

Impression and Recommendations ____

____

Health Care Provider's Signature____ **Date** __________________

Print Name ____ Phone Number _______________________________

____
Street City State Zip

Revised: 02/2013