Mandatory Health Form

To be completed by ALL full-time students

Mail completed forms to:
West Liberty University
Student Health Services
208 University Drive, CUB 127
West Liberty, WV 26074
or fax to 304-336-8315
For questions, call 304-336-8049 or e-mail
healthservices@westliberty.edu

PLEASE PRINT LEGIBLY IN ENGLISH

Name:_____Gender: ◯ Male ◯ Female
LAST FIRST MIDDLE

Date of Birth:_____ Student ID No:_____

Email address:_____ Cell Phone:_____

Home Address:_____
STREET CITY STATE ZIP CODE

Semester Entering: ◯ Fall ◯ Spring ◯ Summer Year_____

•Intended Major:_____* **I give my permission to WLU Student Health Services to provide a copy of this Mandatory Health Form to (if entering one of the following programs): Dental Hygiene, Nursing, Athletic Training, Exercise Physiology, or Medical Lab Science* ◯ Yes ◯ No

•Are you an athlete? ◯ Yes ◯ No If yes, your intended sport_____
**I give my permission to WLU Student Health Services to provide a copy of this Mandatory Health Form to the athletic program marked above so that I may participate.* ◯ Yes ◯ No

•I give my permission for WLU Student Health Services to provide a copy of my immunization record to the Office of Admissions to meet the requirements for my admission to West Liberty University. ◯ Yes ◯ No

•I give my permission for WLU Student Health Services to provide a copy of my immunization record to the Office of Housing and Residential Life to meet the on-campus housing requirements at West Liberty University. ◯ Yes ◯ No

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Emergency Contact:_____Relationship:_____

Address:_____City:_____State:_____

Country:_____Zip:_____Home Phone:_____Cell Phone:_____

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Family Physician:_____Phone:_____

Medical Insurance Company:_____Policy Number:_____

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 all athletes and some Academic programs.

Mandatory Authorization to Render Health Care Services

I authorize WLU Student Health Services to render any services deemed necessary to my health and well-being. In case of an emergency, I grant permission to be transferred to an accredited hospital or other care facility if deemed necessary by the Student Health Service staff or VP of Student Services or his/her designee. It is understood that these designated officials of WLU are in no way financially responsible or liable for any or all medical care, treatment, or surgery performed. 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 WLU Student Health Service for continuity of care.

Student Signature_____Date_____
Parent Signature (if student is under the age of 18)_____Date_____

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Immunizations

To be completed and signed by your health care provider or you may attach a signed copy from your physician

Student Name (please print):_____**Student ID No:**_____

Required for Admission:

•MMR (Measles, Mumps, Rubella)

•Dose 1 given at age 12-15 months of age or later _____/_____ (M Y)

•Dose 2 given at age 4-6 years or later _____/_____ (M Y)

•Or a blood screening (titer) for each disease that proves you have immunity. Please attach results.

Required for On-Campus Housing:

•Meningococcal (One dose received after the age of 16)

•Quadrivalent A,C,Y,W (Menactra, Menveo, MenHibrix, or Menomune) _____/_____ (M Y)

Required for students entering Athletic Training, Dental Hygiene, Exercise Physiology, Nursing, & Medical Lab Science:

•Hepatitis B (series of three injections)

•Dose 1 _____/_____ (M Y) •Dose 2 _____/_____ (M Y) •Dose 3 _____/_____ (M Y)

•Or a blood screening (titer) that proves you have immunity. Please attach results.

•Tuberculosis Screening

•PPD Tuberculin Skin Test

•1st Step Date Given _____/_____/_____ (M D Y) Date Read _____/_____/_____ (M D Y)

Result: _____mm of Induration Interpretation: ◯ Positive ◯ Negative

•2nd Step (if required)_____/_____/_____ (M D Y) Date Read _____/_____/_____ (M D Y)

Result: _____mm of Induration Interpretation: ◯ Positive ◯ Negative

•Chest X-ray (required if PPD is positive)

Result: ◯ Normal ◯ Abnormal Date of X-ray: _____/_____/_____ (M D Y)

•Varicella (Series of two injections)

•Dose 1 _____/_____ (M Y) Dose 2 _____/_____ (M Y)

•Or history of disease: ◯ Yes ◯ No

•Or a blood screening (titer) that proves you have immunity. Please attach results.

Highly Recommended Immunizations for all students:

•Tdap (tetanus, diptheria, acellular pertussis) 1 dose received within the last 10 years that contains all three components.

•Date: _____/_____ (M Y)

•Meningococcal B (Trumenba, Bexsero--Two doses of the same vaccine received after the age of 16)

•Dose 1 _____/_____ •Dose 2 _____/_____

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Health Care Provider's Signature_____**Date**_____

(Required for verification of immunizations)

Personal Health History

To be completed by student

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Student Name (please print):_____**Student ID No:**_____

1. Are you allergic to any medications? ◯Yes ◯No If yes, please explain_____
2. Do you have any other allergies (food, environmental, etc)? ◯Yes ◯No If yes, please explain_____
3. Do you take any medications regularly? ◯Yes ◯No If yes, please list them_____

_____

4. Are you presently under any medical treatment? If yes, please explain_____
5. Have you ever been hospitalized? ◯Yes ◯No If yes, please list dates and reason_____
6. Have you ever had a head injury or a concussion? ◯Yes ◯No If yes, please explain and list dates_____
7. Have you ever been advised not to engage in contact sports? ◯Yes ◯No If yes, please explain_____
8. Do you have a physical impairment such as loss of hearing, loss of vision, paralysis, or absence of one or more paired organs such as kidney, testicles, eye, ear or lung? ◯Yes ◯No IF yes, please explain_____
9. Have you ever experienced chest pain or discomfort with exercise? ◯Yes ◯No
10. Have you ever fainted or come near fainting with exercise? ◯Yes ◯No
11. Have you ever suffered extreme fatigue and inability to walk or talk several minutes to an hour after exercise? ◯Yes ◯No
12. Have you ever been diagnosed with a heart murmur or any other heart issue? ◯Yes ◯No
13. Have you ever been restricted from sports or other activities because of a heart condition? ◯Yes ◯No
14. Has a Physician ever ordered testing on your heart? ◯Yes ◯No
15. Has anyone in your immediate family died before the age of 50 due to heart disease? ◯Yes ◯No
16. Is anyone in your family under the age of 50 disabled by any condition that effects their heart? ◯Yes ◯No
17. Have you ever had high blood pressure (above 120/80 either number)? ◯Yes ◯No
18. Have you ever been diagnosed by a physician with heat exhaustion or stroke? ◯Yes ◯No
19. Date of your last Tetanus shot?_____
20. Have you ever been tested for Sickle Cell Trait? ◯Yes ◯No *If yes, was the result *Positive* or *Negative*? (please circle one)

(Athletes: If you have NOT been tested for Sickle Cell Trait, you must have this done prior to any intercollegiate athletic participation.)

Please check all that apply to you (past or present):

◯ Anemia	◯ Anxiety/Depression	◯ Asthma
◯ Bladder/Kidney problems	◯ Bleeding Disorders	◯ Blood Clots (leg/lung)
◯ Cancer (Type_____)	◯ Chest pain	◯ Diabetes
◯ Fractures (Where?_____)	◯ Gastrointestinal Disorders	◯ Headaches
◯ Heart Defects	◯ Mononucleosis	◯ Seizures
◯ STD's	◯ Shortness of Breath	◯ Syncope (Fainting)
◯ Suicidal Thoughts	◯ Thyroid Disease	◯ Tuberculosis

Please explain any "yes" answers or any answers that you checked above (use additional paper if necessary)_____

_____

Social Habits

Tobacco Use: ◯ Yes ◯ No If previous smoker, please list quit date_____How many years did you smoke?_____

If current smoker, how many packs per day?_____How long have you smoked?_____

Alcohol Use: ◯ Yes ◯ No If yes, how many drinks per week?_____

Recreational Drug Use: ◯ Yes ◯ No If yes, please list drug(s) used_____

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I attest, to the best of my knowledge, that all information provided is accurate and complete.

Student Signature:_____**Date**_____

Parent/Guardian Signature (if student is under age 18)_____**Date**_____

Physical Examination

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A physical is required for ALL Athletes and some Academic Programs*

(*Such as Nursing, Dental Hygiene, Athletic Training, Exercise Physiology, and Medical Lab Science. Please check your program requirements)

Student Name (please print): _____ **Student ID No:**_____

Intended Sport:_____ **Intended Major:**_____

To Be Completed By Your Health Care Provider

Height_____ Weight_____ Blood Pressure_____ Pulse_____ Respiration_____

Eyes: Glasses ◯ Yes ◯ No Contact Lenses ◯ Yes ◯ No Is vision uncorrectable? ◯ Yes ◯ No

Hair, Scalp, Skin	**Normal** or **Abnormal**	Breasts	**Normal** or **Abnormal**
Head	**Normal** or **Abnormal**	Abdomen	**Normal** or **Abnormal**
Hearing	**Normal** or **Abnormal**	Spleen	**Normal** or **Abnormal**
Ear, Nose, Throat	**Normal** or **Abnormal**	Back/Spine	**Normal** or **Abnormal**
Teeth	**Normal** or **Abnormal**	Reflexes	**Normal** or **Abnormal**
Neck: Thyroid	**Normal** or **Abnormal**	Genitalia	**Normal** or **Abnormal**
Cardiovascular	**Normal** or **Abnormal**	Menstruation	**Normal** or **Abnormal**
Lungs	**Normal** or **Abnormal**	Rectum	**Normal** or **Abnormal**

•Recommendations for physical activity: ◯ Unlimited ◯ Limited-please explain_____

_____

•Please list current medications:_____

•Please note allergies or sensitivities:_____

•Does the student require a special diet?_____

•Is the 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**_____

Address:_____**City**_____**State**_____**Zip**_____

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To Be Completed by West Liberty University Athletic Trainer for Athletes Only

	Knee Ligament				Hamstring Flexibility	Adductor Flexibility	Hip Flexor Flexibility	Foot Posture		
	MCL	ACL	PCL	LCL				Pes P	Pes C	WNL
L										
R										

	Shoulder						Elbow	Spinal Posture		
	Int Rot	Ext Rot	Flexion	Abduction	Apprehension	Ho A	UCL	Cerv	Thor	Lumb
L										
R										