**Student Health Service**

*Return completed forms to:*

West Liberty University

Health Service-Attn: PA Program 208 University Drive

College Union Box 127 West Liberty, WV 26074

*Fax: 304-336-8315.*

**CONFIDENTIAL MANDATORY HEALTH FORM**

## Section I: Health Questionnaire

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

Name:

Last First MI

Semester Entering: Fall Spring Summer Year\_

Student ID No:

Status: Graduate Student PA Program

Date of Birth:

Gender: Male Female Marital Status: S M

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.*

## Section I: Health History

1. Are you allergic to medications? Yes No Describe

Do you have any other allergies? Yes No Describe

1. Do you take any medications regularly? Yes No If yes, please list them.
2. Medical History: Check all that apply to you –past or present.

|  |  |  |  |
| --- | --- | --- | --- |
| High Blood Pressure  Heart Disease | Asthma  Bronchitis | Hepatitis or jaundice  Gall Bladder disease | Headaches  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 |
| Color blindness | Loss of joint motion | Inability to lift or bend | Loss of vision |

1. 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.

1. I will be entering the **Master of Science in Physician Assistant Studies Program.**

I give my permission to the West Liberty University Health Service to provide information of this Mandatory Health Form to the program marked above as required by that program (status of health and immunizations). Actual form is confidential and will be kept in the Health Services files only). Yes No

1. 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

1. 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 less than 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 the case of an emergency, I authorize to sign any and all necessary medical forms in my behalf: Dean of Enrollment and Student Services, WLU Health Service Staff, Director of 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



Name Last First MI

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## Section III: Physical Examination

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

Height

Weight

Blood Pressure

Pulse

Respiration

Eyes Glasses: \_ Yes No Contact Lenses: Yes \_ No Color Vision: Yes No Visual Acuity: Uncorrected: R. /20 L. /20 Corrected: R. /20 L. /20

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

Recommendations for physical activity 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

The student is physically qualified to undergo a graduate-level training program? Yes No

Health Care Provider’s Signature

Date

Print Name Phone Number

Address: \_ Street City State Zip