WEST LIBERTY UNIVERSITY

Student Health Service

Return completed forms to:
WLU Health Service
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 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: _____ _____ _____ 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

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.

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 the following programs: ☐ **Dental Hygiene** ☐ **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** _____

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 the case of an emergency, to sign any and all necessary medical forms in my behalf: VP of Student Affairs, 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**

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Name _____
Last First MI

_____ **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

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: 05/2009