*Return completed forms to:*

WLU Student Health Services
208 University Drive, CUB 127
West Liberty, WV 26074

*Or Fax to: 304-336-8315*

# Health Screening Form
# Physician Assistant Program

***Student: Please complete and sign section 1 then, return form to the above address.***

***Section 1.***

Name : (print) _____

I hereby give consent to the West Liberty University Student Health Services to provide the information requested in section II for the purpose of determining my ability to participate in activities related to my education and training in the Physician Assistant Program. I further understand my actual health record will be held in the Student Health Services center and are subjected to privacy laws.

_____ _____
Signature of student Date

***West Liberty University Student Health Services Center personnel: Please complete section 2 then, return form to the Physician Assistant Program.***

***Section 2.***

West Liberty University Student Health Services personnel: Please attach a copy of immunizations and verify that the student was found
qualified _____ / not qualified _____ (check one) to participate in the Physician Assistant Program by his or her medical provider.

_____ _____
Signature of Health Care Services personnel Date

***West Liberty University Physician Assistant Program: Please verify all above information is correct and check the appropriate box. Sign and date where indicated.***

***Section 3.***

Upon review of the above information, the Physician Assistant student is found to be:
Qualified _____/ Not qualified_____ to participate in the program.

_____ _____
WLU PA Program representative signature Date

WEST LIBERTY UNIVERSITY

## Student Health Service

*Return completed forms to:*

WLU Student Health Services
208 University Drive, CUB 127
West Liberty, WV 26074

*Fax: 304-336-8315*

# CONFIDENTIAL MANDATORY HEALTH FORM – PA PROGRAM

**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 Student Health Services, 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: ☐ 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**

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 |
| ☐ Color blindness | ☐ Loss of joint motion | ☐ Inability to lift or bend | ☐ Loss of vision |

**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.** 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

**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 _____

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**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**

WEST LIBERTY UNIVERSITY

*Return completed forms to:*
West Liberty University
Health Service-Attn: PA Program
208 University Drive
College Union Box 127
West Liberty, WV 26074

*Fax: 304-336-8313*

Name _____
Last First MI

**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

**IMMUNIZATIONS**

# WEST LIBERTY UNIVERSITY
# PHYSICIAN ASSISTANT STUDIES PROGRAM

**Return Completed form to:**
WLU Student Health Services
208 University Drive, CUB 127
West Liberty, WV 26074-0295
or fax to: 304-336-8315

## Confidential Mandatory Health Form

***(To be completed and signed by your health care provider)***

**Name: _____ (*Last, First, MI*) WLU Student @#: _____**

| | |
|---|---|
| **Hepatitis B** | Immunization is required for all students. This series of two or three immunizations AND post-vaccination antibody titer for proof of immunity is required.<br><br>Dates immunizations were given: 1. _____ (M/Y) 2. _____ (M/Y) 3. _____ (M/Y) |
| **Hepatitis B antibody titer (required)** | Hepatitis B surface antibody titer 1 – 2 months after final dose:<br><br>Titer date: _____ (M/Y) Results: _____ (results MUST be attached) |
| **Influenza** | Immunization is required each year. Date: _____ (M/Y)<br>*Current year vaccine will be required in the fall of each year while enrolled |
| **Covid-19**<br>**Current booster:**<br><br>**Previous doses:** | 2024-2025 updated Covid vaccine: Brand/Date _____ \| _____ (M/Y)<br><br>Brand/Dates: 1. _____ \| _____ (M/Y) 2. _____ \| _____ (M/Y) 3. _____ \| _____ (M/Y)<br><br>*Please attach copy of CDC Covid 19 vaccine card.* |
| **Measles-Mumps-Rubella (MMR)** | Series of 2 doses of live MMR vaccine. (2nd dose must be separated by <u>at least</u> 28 days from the 1st dose).<br><br>1. _____ (M/Y) 2. _____ (M/Y) ***<u>OR</u>*** ***may provide MMR titers below*** |
| **Measles antibody titer** (if no proof of vaccination) | Measles Antibody titer: _____ (M/Y) Results: _____ (results MUST be attached) |
| **Rubella antibody screening** (if no proof of vaccination) | Rubella antibody titer: _____ (M/Y) Results: _____ (results MUST be attached) |
| **Mumps antibody titer** (if no proof of vaccination) | Mumps antibody titer: _____ (M/Y) Results: _____ (results MUST be attached) |
| **Chicken Pox (Varicella)** | 2 doses of the vaccine, at least 28 days apart<br><br>Date given: 1. _____ (M/Y) 2. _____ (M/Y) ***<u>OR</u>*** |
| **Varicella antibody titer** (if no proof of vaccination) | Titer date: _____ (M/Y) Results: _____ (results MUST be attached) |
| **Healthcare Provider Varicella attestation** | Patient has a documented history of varicella or herpes zoster:<br>M/Y of illness: _____ Provider initials: _____ (documentation MUST be attached) |
| **Tetanus/Diphtheria/Pertussis** | Primary series of 4 doses with DTaP or DT<br>Dates given: 1. _____ (M/Y) Tdap Booster*: _____ (M/Y)<br>2. _____ (M/Y)<br>3. _____ (M/Y) *Must have been <u>within the last 10 yrs</u>.<br>4. _____ (M/Y) |
| **Bacterial Meningitis** ***(Strongly recommended)*** | MenACWY: Date given: 1. _____ (M/Y) 2. _____ (M/Y)<br><br>MenB: Date given: 1. _____ (M/Y) 2. _____ (M/Y) |

***Please note: 1) Within 3 months after beginning our PA Program, all students will be required to have a two-step PPD test for tuberculosis according to CDC healthcare worker guidelines. Each of these tests will cost approximately $20.00. 2) If history of positive PPD, chest X-ray results required. 3) IGRA/QuantiFERON is acceptable in lieu of two-step PPD. IGRA/QuantiFERON is necessary instead of PPD if history of receiving BCG. 4. Covid 19 CDC immunization recommendations as of 3/4/25 and are subject to change.***

***(Form updated March 4, 2025)***

**Health Care Provider's Signature: _____ Date: _____**

# Healthcare Personnel Vaccination Recommendations[1]

## VACCINES AND RECOMMENDATIONS IN BRIEF

**COVID-19** — If not up to date, give COVID-19 vaccine according to current CDC recommendations (see www.cdc.gov/acip-recs/hcp/vaccine-specific/covid-19.html).

**Hepatitis B** — If no previous dose, give either a 2-dose series of Heplisav-B or a 3-dose series of either Engerix-B or Recombivax HB. A 3-dose series of Twinrix vaccine, which prevents hepatitis A and B, is an option. For HCP who perform tasks that may involve exposure to blood or body fluids, obtain antibody serology 1–2 months after final dose.

**Influenza** — Give 1 dose of influenza vaccine annually.

**MMR** – For healthcare personnel (HCP) born in 1957 or later without serologic evidence of immunity or prior vaccination, give 2 doses of MMR, 4 weeks apart. For HCP born prior to 1957, see below.

**Varicella (chickenpox)** — For HCP who have no serologic proof of immunity, prior vaccination, or diagnosis or verification of a history of varicella or herpes zoster (shingles) by a healthcare provider, give 2 doses of varicella vaccine, 4 weeks apart.

**Tetanus, diphtheria, pertussis** — Give 1 dose of Tdap as soon as feasible to all HCP who have not received Tdap previously and to pregnant HCP with each pregnancy (see below). Give Td or Tdap boosters every 10 years thereafter.

**Meningococcal** — Give both MenACWY and MenB to microbiologists who are routinely exposed to isolates of *Neisseria meningitidis*. As long as risk continues: boost with MenB after 1 year, then every 2–3 years thereafter; boost with MenACWY every 5 years.

*Hepatitis A, typhoid, and polio vaccines are not routinely recommended for HCP who may have on-the-job exposure to fecal material. Polio vaccination is recommended for adults known or strongly suspected of being unvaccinated (see CDC recommended adult immunization schedule at www.cdc.gov/vaccines/hcp/imz-schedules/adult-age.html).*

### Hepatitis B

All HCP who cannot document previous vaccination should receive either a 2-dose series of Heplisav-B at 0 and 1 month or a 3-dose series of Engerix-B, Recombivax HB, or Twinrix at 0, 1, and 6 months. HCP who perform tasks that may involve exposure to blood or body fluids should be tested for hepatitis B surface antibody (anti-HBs) 1–2 months after dose #2 of Heplisav-B or dose #3 of Engerix-B or Recombivax HB to document immunity.

- If anti-HBs is at least 10 mIU/mL (positive), the vaccinee is immune. No further serologic testing or vaccination is recommended.
- If anti-HBs is less than 10 mIU/mL (negative), the vaccinee is not protected from hepatitis B virus (HBV) infection, and should receive another 2-dose or 3-dose series of HepB vaccine on the routine schedule, followed by anti-HBs testing 1–2 months later. A vaccinee whose anti-HBs remains less than 10 mIU/mL after 2 complete series is considered a "non-responder."

**For non-responders:** HCP who are non-responders should be considered susceptible to HBV and should be counseled regarding precautions to prevent HBV infection and the need to obtain HBIG prophylaxis for any known or probable parenteral exposure to hepatitis B surface antigen (HBsAg)-positive blood or blood with unknown HBsAg status. Non-responders should be tested for HBsAg and anti-HBc to determine infection status. Infected HCP should be counseled and medically evaluated.

**For HCP with documentation of a complete 2-dose (Heplisav-B) or 3-dose (other HepB-containing vaccines) series but no documentation of anti-HBs of at least 10 mIU/mL (e.g., those vaccinated in childhood):** HCP who are at risk for occupational blood or body fluid exposure might undergo anti-HBs testing upon hire or matriculation. See references 2 and 3 for details.

### Influenza

All HCP, including students and volunteers, in any healthcare setting should receive annual influenza vaccination. Live attenuated influenza vaccine (LAIV) may only be given to non-pregnant healthy HCP age 49 years and younger. HCP who receive LAIV should avoid close contact with severely immunosuppressed patients (e.g., stem cell transplant recipients) who require protective isolation for at least 7 days after vaccine administration.

### Measles, Mumps, Rubella (MMR)

HCP who work in medical facilities should be immune to measles, mumps, and rubella.

- HCP born in 1957 or later can be considered immune to measles, mumps, or rubella only if they have documentation of (a) laboratory confirmation of disease or immunity or (b) appropriate vaccination against measles, mumps, and rubella (i.e., 2 doses of live measles and mumps vaccines given on or after the first birthday and separated by 28 days or more, and at least 1 dose of live rubella vaccine). HCP with 2 documented doses of MMR are not recommended to be serologically tested for immunity; but if they are tested and results are negative or equivocal for measles, mumps, and/or rubella, these HCP should be considered to have presumptive evidence of immunity to measles, mumps, and/or rubella and are not in need of additional MMR doses.
- Although birth before 1957 is considered acceptable evidence of measles, mumps, and rubella immunity, 2 doses of MMR vaccine should be considered for unvaccinated HCP born before 1957 who do not have laboratory evidence of disease or immunity to measles and/or mumps. One dose of MMR vaccine should be considered for HCP with no laboratory evidence of disease or immunity to rubella. For these same HCP who do not have evidence of immunity, 2 doses of MMR vaccine are recommended during an outbreak of measles or mumps and 1 dose during an outbreak of rubella. HCP who have had 2 doses of MMR and are identified by public health authorities as being at increased risk for mumps because of an outbreak should receive a third dose of MMR to improve protection.

### Varicella

All HCP should be immune to varicella. Evidence of immunity in HCP includes documentation of 2 doses of varicella vaccine given at least 28 days apart, laboratory evidence of immunity, laboratory confirmation of disease, or diagnosis or verification of a history of varicella or herpes zoster (shingles) by a healthcare provider.

### Tetanus/Diphtheria/Pertussis (Td/Tdap)

All HCPs who have not or are unsure if they have previously received a dose of Tdap should receive a dose of Tdap as soon as feasible, without regard to the interval since the previous dose of Td. Pregnant HCPs should be revaccinated during each pregnancy. All HCPs should then receive Td or Tdap boosters every 10 years thereafter.

### Meningococcal

Microbiologists who are routinely exposed to isolates of *N. meningitidis* should be vaccinated with both MenACWY and MenB vaccines. MenACWY and MenB vaccination may be administered on the same day. A combination MenABCWY vaccine is an option when both products are indicated at the same visit. The minimum interval between MenABCWY doses is 6 months.

#### REFERENCES


1 CDC. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). *MMWR*, 2011; 60(RR-7).

2 CDC. Prevention of Hepatitis B Virus Infection in the United States. Recommendations of the Advisory Committee on Immunization Practices. *MMWR*, 2018; 67(RR1):1–30.

3 Immunize.org. Pre-exposure Management for Healthcare Personnel with a Documented Hepatitis B Vaccine Series Who Have Not Had Post-vaccination Serologic Testing. Accessed at www.immunize.org/catg.d/p2108.pdf.


For additional specific ACIP recommendations, visit CDC's website at www.cdc.gov/acip-recs/site.html or visit Immunize.org's website at www.immunize.org/official-guidance/cdc/acip-recs/vaccines/.