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