



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.

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**Signature of Parent or Legal Guardian (if applicable)** \_\_\_\_\_ **Date** \_\_\_\_\_

