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. 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: Titer date: _____ (M/Y) Results: _____ (results MUST be attached)
Influenza	Immunization is required each year. Most Recent Vaccine Date: _____ (M/Y) *Current year vaccine will be required in the fall of each year while enrolled
Covid-19 **Current booster:** **Previous doses:**	2025-2026 Covid vaccine: Brand/Date _____ | _____ (M/Y) Brand/Dates: 1. _____ | _____ (M/Y) 2. _____ | _____ (M/Y) 3. _____ | _____ (M/Y) *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). 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 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: M/Y of illness: _____ Provider initials: _____ (documentation MUST be attached)
Tetanus/Diphtheria/Pertussis	Primary series of 4 doses with DTaP or DT Dates given: 1. _____ (M/Y) Tdap Booster*: _____ (M/Y) 2. _____ (M/Y) 3. _____ (M/Y) *Must have been <u>within the last 10 yrs</u>. 4. _____ (M/Y)
Bacterial Meningitis ***(Strongly recommended)***	MenACWY: Date given: 1. _____ (M/Y) 2. _____ (M/Y) 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 3/30/26 and are subject to change.

(Form updated March 30, 2026)

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