



- 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 \_\_\_\_\_

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**Section II: 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 case of an emergency, I grant the following people permission to sign any and all necessary medical forms on my behalf: Dean of Enrollment and Student Services, WLU Health Service Staff, Director of Housing and 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

Return completed forms to:  
 West Liberty University  
 Department of Health Services  
 208 University Drive  
 College Union Box 127  
 West Liberty, WV 26074-0295  
 Or Fax: 304-336-8315

**WLU Health Service**  
**CONFIDENTIAL MANDATORY HEALTH FORM (Cont.)**

**TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.**

*All information must be in English.*

Name \_\_\_\_\_ Student ID No: \_\_\_\_\_  
Last First MI

**Section III: IMMUNIZATIONS**

**■REQUIRED IMMUNIZATION:**

**A. M.M.R. (Measles, Mumps, Rubella)**

- 1. Dose 1 given at age 12-15 months or later ..... #1 \_\_\_\_/\_\_\_\_  
M Y
- 2. Dose 2 given at age 4-6 years or later, and at least one month after first dose. .... #2 \_\_\_\_/\_\_\_\_  
M Y

**■HIGHLY RECOMMENDED IMMUNIZATIONS (B through G):**

**B. TETANUS-DIPHTHERIA -PERTUSSIS**

- 1. Primary series of four doses with DTaP or DTP:  
 #1 \_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_ #4 \_\_\_\_/\_\_\_\_  
M Y M Y M Y M Y
- 2. Tetanus-Diphtheria-Pertussis (Tdap) booster within the last ten years ..... \_\_\_\_/\_\_\_\_  
M Y

**C. MENINGOCOCCAL (One dose — received after the age of 16 but preferably at entry into college for freshmen living in residence halls.)**

- Tetravalent conjugate vaccine (**Menactra®**), preferred Date \_\_\_\_/\_\_\_\_ **OR**  
M Y
- Tetravalent polysaccharide vaccine (**Menamune®**) Date \_\_\_\_/\_\_\_\_  
M Y

**D. POLIO (OPV/IPV)**

- 1. OPV alone (oral Sabin three doses): #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_ OR
- 2. IPV alone (injected Salk four doses): #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_ #4 \_\_\_\_/\_\_\_\_/\_\_\_\_

**■REQUIRED IMMUNIZATIONS FOR DENTAL HYGIENE AND NURSING PROGRAMS (E, F, and G):**

**E. HEPATITIS B**

- 1. Dose #1 \_\_\_\_/\_\_\_\_ Dose #2 \_\_\_\_/\_\_\_\_ Dose #3 \_\_\_\_/\_\_\_\_  
M Y M Y M Y
- 2. Hepatitis B surface antibody Date \_\_\_\_/\_\_\_\_ Result:  Reactive  Non-reactive  
M Y

**F. TUBERCULOSIS SCREENING**

- 1. PPD Tuberculin Skin Test:  
 Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y M D Y  
 Result: \_\_\_\_\_ mm of induration Interpretation:  Positive  Negative
- 2. Chest x-ray (required if PPD test is positive) Result:  Normal  Abnormal Date of x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

**G. VARICELLA**

- 1. History of Disease:  Yes  No
- 2. Varicella antibody \_\_\_\_/\_\_\_\_ Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_  
M Y
- 3. Immunization: Dose #1 \_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_  
M Y M Y

Health Care Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

**(Required for verification of immunizations)**

