



DATE:

NAME:

STUDENT ID#:

BIRTHDATE:

HEALTH SCREEN:

Age: _____

Place Of Birth _____

Are you currently being treated by a health care professional for any condition(s)?

Are you taking any medications regularly or as needed (other than aspirin/Tylenol?) _____

Medical History

NO YES Contagious skin rashes

NO YES Other than at birth, have you ever had hepatitis or other liver disease? List:

NO YES Do you have any other medical conditions not mentioned above?

Student Signature

Date

I have screened this patient and found them to be free of communicable illness.

MD, DO, ARNP, PA or RN Signature

Date