*This form is NOT required for medical students, EMT, Masters of Clinical Nutrition, Dentistry, and Speech Pathology students. Check with your program if unsure on the completion of this form.*

HEALTH SCREENING FORM:

Age: __________ Place Of Birth: __________________________

Are you currently being treated by a health care professional for any condition(s)? List: __________________________________________
____________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________

Are you taking any medications regularly or as needed (other than aspirin/Tylenol)? List: ____________________________
____________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________

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.

_______________________________________________   __________________________
RN, ARNP, PA, DO or MD Signature   Date

CLINIC STAMP:
Email this form to: student-health@uiowa.edu AND submit to your program if they require this form