Health Screening Form

At present, this form is **ONLY** required by the College of Nursing, College of Pharmacy, Physical Therapy, Nurse Midwife, Perfusion, Physician Assistant & Radiation Science programs. Return the completed form **to your program NOT Student Health.** Check with your Program Coordinator if unsure as to whether or not you need this form completed and submitted to your program.

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 Name, Address & Phone: OR Clinic Stamp:

___________________________________________________________________________________________________

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If you have any questions feel free to email: student-immunizations@uiowa.edu

*Turn This Form In To Your Program Coordinator if your program requires it – NOT STUDENT HEALTH*

8/1/24