IOWA | Student Health

DATE:

NAME:

STUDENT ID#:

BIRTHDATE:

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 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