

Health Screening Form

School of Nursing and PA Institute

This form must be completed in its entirety by a licensed physician, physician assistant, or nurse practitioner annually for all nursing and PA students. For newly matriculating students, Health Form A, Sections **A**, **B** and **E** must be completed and submitted in conjunction with this form. Students must maintain a copy of the completed form for their records to be submitted to their program's clinical tracking system.

Instructions for Health Care Provider: Students are required to receive a comprehensive medical examination and be medically cleared to ensure they are equipped to meet the demands of a career in healthcare.

Students may register with Student Accessibility Services for accommodation needs. <https://www.bridgeport.edu/student-accessibility/>

Student Last Name	Student First Name	UB ID#	Date of Birth: ____/____/____ Month Day Year
E-mail	Phone () -	Sex Assigned at Birth	Gender Identity
Clinical Program (Choose One): <input type="checkbox"/> School of Nursing <input type="checkbox"/> PA Institute			

To be completed by Physician/Health Care Provider			
Is this student cleared for the full physical and emotional demands of the University of Bridgeport's graduate or undergraduate programs in Health Sciences or Nursing, including clinical/patient care?			
<input type="checkbox"/> Yes/Unlimited activity and fit for program participation			
<input type="checkbox"/> No/Limited activity			
Reason: _____ _____			
Recommendation: _____ _____			
Your signature certifies that you have completed a comprehensive history and physical examination of the above-named student and the information is accurate and complete to the best of your knowledge.			
Physician/Health Care Provider's Information (Please print clearly):			
Signature of Health Care Provider			Date: ____/____/____ Month Day Year
Last Name	First Name		Phone: () -
Street	City	State	Zip Code