OFFICE OF ACADEMIC & STUDENT AFFAIRS
School of Pharmacy and Health Professions | Creighton University

Health Information Release Form

My signature on this form indicates my consent for the Creighton University School of Pharmacy and Allied Health Professions to release information concerning my criminal background and my immunization status to University officials and/or School faculty (including volunteer faculty preceptors and fieldwork educators) in order to facilitate the completion of my educational program.

Signature _____

Printed
Name_____

Date_____