Marshfield Clinic
Health System

Health Information Report

Completed Health Information Report must be received a minimum of 4 weeks prior to your experience.

Name *(first, MI, last)* _____ Date of birth _____

Must provide medical documentation of vaccination or titer OR disease history OR combination for each of the following:

Required Information	2 Immunization Dates		Titer Date	Result*
Measles (Rubeola)				
Mumps				
Rubella				
Varicella (Chicken pox)				

Required Information	3 Immunization Dates			Titer Date	Result*
Hepatitis B					

Reported *for tracking purposes only*	Initial Date	Secondary Date	Booster Date	Name of Vaccine
COVID-19 Vaccination				

Required Information	1 Immunization Date
Tdap (received in May 2005 or later)	
Annual influenza vaccine (current season)	

*If titer results are equivocal, non-reactive/non-immune, re-immunization information must be provided.

TB Option 1

Must provide a 2 step TB test result that has been completed within the past 12 months.

Must provide a two step PPD (TB skin test) results:
- Must be completed within 1 – 3 weeks of each other
- Annual TB questionnaire

TB skin test

Date placed _____ /_____ /_____ Date placed _____ /_____ /_____

Date read _____ /_____ /_____ Date read _____ /_____ /_____

Result _____ mm Result _____ mm

TB Option 2

Results of IGRA test can be submitted in place of the 2-step PPD. This test will require a blood draw.
- Annual TB questionnaire

IGRA TB test

Date IGRA TB test taken _____ /_____ /_____

Result _____

Positive TB Result

If you have received a positive PPD result, you must provide the following:
- Positive PPD date and result including mm induration
- Copy of chest x-ray including the date of x-ray
- Annual TB questionnaire

TB skin test

Date placed _____ /_____ /_____

Date read _____ /_____ /_____

Result _____ mm

Chest x-ray

Date taken _____ /_____ /_____

Result _____

Attach a copy of chest x-ray results

Complete page 2 for Annual Student/Learner TB Health Assessment

Questions, call 1-800-541-2895. Submit immunization records and titers (and/or additional supporting documentation) via email to: studentprograms@marshfieldclinic.org

Marshfield Clinic follows CDC Immunization Guidelines of Health Care Workers

Student/Learner Annual TB Health Assessment (Page 2)

Completed Health Information Report must be received a minimum of 4 weeks prior to your experience.

Have you experienced any clinical related injury/illness/significant exposure this past year ..... ☐ Yes ☐ No
If yes, explain _____

Do you have patient contact ..... ☐ Yes ☐ No

Have you prepared or administered chemotherapy or handle the urine of patients who receive chemotherapy..... ☐ Yes ☐ No
If yes, do you have any new or unexplained medical problems ..... ☐ Yes ☐ No

Have you performed functions as part of a clinical experience in an air ambulance *(helicopter or airplane)*... ☐ Yes ☐ No

List any known ALLERGIES *(i.e. medications, Latex, thimerosal, etc.)*: _____

_____

_____

Check (✔) if you currently have any of the following symptoms:

- ☐ Persistent productive cough *(greater than 2 weeks duration unrelated to another diagnosis)*
- ☐ Night sweats *(unrelated to menopause)*
- ☐ Unexplained weight loss
- ☐ Coughing up blood
- ☐ Loss of appetite
- ☐ Fever, with unknown cause

To your knowledge, during the course of these past 12 months, have you been exposed to a patient with known active TB..... ☐ Yes ☐ No
If yes, explain _____

To your knowledge, have you had an exposure to a known active TB patient in the community setting or at home this past year (i.e. a relative, friend, or other contact)..... ☐ Yes ☐ No
If yes, explain _____

Have you had a positive TB blood assay test in the past ..... ☐ Yes ☐ No
If yes, when _____

Have you traveled outside of the U.S. and/or Canada for greater than a total of 60 days in the last year ..... ☐ Yes ☐ No
If yes, where _____

Have you had a clinical experience outside of MCHS in the last year..... ☐ Yes ☐ No

Have you performed missionary work in the last year, either in or out of the U.S..... ☐ Yes ☐ No

Were you out of the U.S. on military duty in the last year ..... ☐ Yes ☐ No

Contact Student Programs if you have had an exposure to a known active TB patient or develop any of the above symptoms or concerns during your clinical rotation/experience.

My signature certifies that the above information is true and complete and will become part of my student health record.

Student/Learner (print) _____

Student/Learner signature _____ Date _____

