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 _____

**Attach documented proof of immunization records (Wisconsin Immunization Record [WIR], or Regional Early Childhood Immunization Network [RECIN]) OR have health care provider sign below verifying information. 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 | | | | |
| **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.

**Must provide TB status within the last 12 months either by PPD OR IGRA test OR negative chest x-ray.**

| | | |
|---|---|---|
| **Option 1**<br>Must provide two PPD (TB skin test) results:<br>– One within the last 12 months<br>– One from the previous year (no more than 12 months prior to the above result)<br>If you have never received this test or it has been more than 12 months since your last test, you will need to have a 2-step PPD. | **PPD (TB skin test)**<br>Date placed _____ /_____ /_____<br>Date read _____ /_____ /_____<br>Result _____ mm | Date placed _____ /_____ /_____<br>Date read _____ /_____ /_____<br>Result _____ mm |
| **Option 2**<br>If you have received a positive PPD result, you must provide the following:<br>– Positive PPD date and result including mm induration<br>– Copy of chest x-ray including the date of x-ray from within the last 12 months for first-time students<br>– Annual TB questionnaire from within the last 12 months (obtained from your health care provider) | **Positive PPD (TB skin test)**<br>Date placed _____ /_____ /_____<br>Date read _____ /_____ /_____<br>Result _____ mm | **Chest x-ray**<br>Date taken _____ /_____ /_____<br>Result _____<br>Attach a copy of chest x-ray results and TB questionnaire from within the last 12 months. |
| **Option 3**<br>Results of IGRA test can be submitted in place of the 2-step PPD. This test will require a blood draw. | **IGRA TB test**<br>Date IGRA TB test taken _____ /_____ /_____<br>Result _____ | |

**Attach documented proof of immunization records (WIR or RECIN) and titers (lab results) OR have health care provider sign below verifying above information.**

Health care provider signature | PRINT health care provider name | Health care provider address/phone

**Questions, call 1-800-541-2895. Forward the immunization records and titers (and/or additional supporting documentation) by using one of the following routes:**

**Fax information to 715-847-3811** **Email information to studentprograms@marshfieldclinic.org**

**Mail information to: Central District** – Student Programs – 2R6, 1000 North Oak Avenue, Marshfield, WI 54449
**East District** – Student Programs – W2E, 2727 Plaza Drive, Wausau, WI 54401
**North District** – Student Programs, P.O. Box 1390, Minocqua, WI 54548
**Northwest District** – Student Programs, 1700 West Stout Street, Rice Lake, WI 54868
**West District** – Student Programs, 2116 Craig Road, Eau Claire, WI 54701

 

***Marshfield Clinic follows CDC Immunization Guidelines of Health Care Workers***