



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 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.

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

<p>Option 1</p> <p>Must provide two PPD (TB skin test) results:</p> <ul style="list-style-type: none"> – One within the last 12 months – One from the previous year (no more than 12 months prior to the above result) <p>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.</p>	<p>PPD (TB skin test)</p> <p>Date placed ____ / ____ / ____ Date placed ____ / ____ / ____</p> <p>Date read ____ / ____ / ____ Date read ____ / ____ / ____</p> <p>Result _____ mm Result _____ mm</p>
<p>Option 2</p> <p>If you have received a positive PPD result, you must provide the following:</p> <ul style="list-style-type: none"> – Positive PPD date and result including mm induration – Copy of chest x-ray including the date of x-ray from within the last 12 months for first-time students – Annual TB questionnaire from within the last 12 months (obtained from your health care provider) 	<p>Positive PPD (TB skin test)</p> <p>Date placed ____ / ____ / ____ Date taken ____ / ____ / ____</p> <p>Date read ____ / ____ / ____ Result _____</p> <p>Result _____ mm Attach a copy of chest x-ray results and TB questionnaire from within the last 12 months.</p>
<p>Option 3</p> <p>Results of IGRA test can be submitted in place of the 2-step PPD. This test will require a blood draw.</p>	<p>IGRA TB test</p> <p>Date IGRA TB test taken ____ / ____ / ____</p> <p>Result _____</p>

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 – WAU, 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