

Annual Reassessment Form for Health Program Students & Faculty

Name: _____ M #: _____

Health Career Program: _____

Please submit this form with updated PPD results, if done elsewhere. You should expect a minimum review time of 48 hours for clearance. You will be notified via your MCC e-mail if you are cleared.

Reassessment Questionnaire

1. Were there changes in your health status in the past year, including new allergies? Yes No
If yes, please explain: _____
2. Have you been treated in the emergency room, or been hospitalized, in the past year? Yes No
If yes, please explain: _____
3. Are there any concerns that might interfere with your ability to perform clinical duties? Yes No
If yes, please explain: _____
4. Please list all medications you are presently taking.

Tuberculosis Screening & Tuberculosis Skin Testing Consent

*All students, including those with a history of past positive tests, must complete the section below for symptoms and sign where indicated.

5. Have you had prior TB testing? Yes No If yes, approximate date: _____
Skin test or Blood test? _____ Results: _____*
6. Have you had any of these symptoms during past year: None
Unexplained Tiredness Coughing Up Blood Unexplained Fevers
Sweating at Night Cough Lasting Three Or More Weeks Unintentional Weight Loss
7. Are you pregnant? Yes No NA
If yes, has MD agreed to PPD testing? Yes No

I have read the above questions, attest to truthfulness in my responses, and consent to (PPD) tuberculin skin testing at MCC Health Services, if indicated (persons with a past positive will not be tested). I authorize that information regarding reactive PPD tests, TB screening results, chest x-rays and/or clearance for clinical placement, may be shared between MCC Health Services and the Monroe County Health Department TB Clinic, if necessary.

Signature: _____ Date: _____