Monroe Community College
STATE UNIVERSITY OF NEW YORK

Health Related Programs
Second Year Student Reassessment Form

Return this completed form to MCC's Health Services on or before:

- June 1st (fall semester program start)
- January 1st (spring semester program start)

Health Related Program: Please Select

Name: _____ M #: _____

Date of Birth: _____ Phone Number: _____

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.

1. Have you had prior TB testing? ◯ Yes ◯ No If yes, approximate date: _____
   Skin test or Blood test? _____ Results: _____
2. Have you had any of these symptoms during past year:
   ☐ Unexplained Tiredness ☐ Coughing Up Blood ☐ Unexplained Fevers
   ☐ Sweating At Night ☐ Cough Lasting Three Or More Weeks ☐ Unintentional Weight Loss
3. Are you currently pregnant? ◯ Yes ◯ No ◯ NA
   If yes, has MD agreed to PPD testing? ◯ Yes ◯ No
4. Have you received any immunizations in the last four weeks, 28 days? ◯ 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: _____

Submit this form with updated PPD results (next page) if completed by an outside provider for reassessment and not completed at MCC's Health Services office. Please anticipate a minimum review time of 48 hours for clearance after your final PPD read. You will be notified via your MCC e-mail if you are cleared.

MCC Health Services, 1000 East Henrietta Road, Building 3, Room 165, Rochester, New York 14623
(585) 292-2018 Fax: 585-292-3856 healthservices@monroecc.edu

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Tuberculosis (TB) Screening

PPD Placement & Read

Please Note: TB screening is not required for Nursing and Surgical Technology Students. Contact your faculty with questions.

PPD Date Placed: _____

Provider Signature: _____

PPD Date Read: _____

PPD Result in mm: _____

PPD Result: Please Select (if positive, see below)

Provider Signature: _____

Or Submit IGRA/T Spot with Lab Results attached.

IGRA/T Spot Date: _____

IGRA/T Spot Result: Please Select

If recent PPD results are ≥ 10mm or IGRA results are positive, a chest x-ray is REQUIRED. If known past positive with negative chest xray, student must complete TB symptom screening form. Submit a copy of the Lab Results.

Date of Chest X-Ray: _____

Result: _____

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