University of Massachusetts
UMASS Medical School

University of Massachusetts
Employee Health Services
55 Lake Avenue North
Worcester, MA 01655

Name_____
Address_____
_____
Telephone _____
Soc. Sec. #: ____/___/____
Date of Birth: ___/___/___ **Age**__
Med. Rec. #: _____

Health Screening & Clearance Form
(H.S. & College Students Learning Program)

History

Medical (student only: asthma, arthritis, anemia, hypertension, diabetes, cancer, heart, lung, kidney, thyroid, tuberculosis, mental illness, or any other chronic medical conditions) If No: _____, If Yes, please list:

Surgical Procedures: If No: _____ If Yes, please list:

Allergies (medications, foods, latex, animals, chemical, seasonal, environmental) If No: _____ If Yes, please list:

Medications (taken on a daily or as needed basis) If No: _____ If Yes, please list:

Have you ever had Chicken Pox? Yes _____ No _____

Please attach the required. *official documentation of the following immunizations
#1. Proof of 2 Measles vaccinations (Rubella or MMR) given after 1967.

#2. Proof of at least 1 Rubella (German Measles) vaccination (or MMR) given after 1967.
#3. Proof of a Tetanus vaccination given within the last 10 yrs.

<u>To be completed by Employee Health Services at UMass/Memorial only</u>

Mantoux Test/PPD within 6 months:

Date Given _____ Date Read _____ Negative _____ Positive _____ mm
CXR _____ pos/neg

COMMUNICABLE DISEASE HISTORY

Chicken Pox _____ Hepatitis B _____ Hepatitis C _____

IMMUNIZATIONS: (give dates, * or ** are mandatory)

* MMR#1 _____ ** Measles _____
* MMR#2 _____ ** Mumps _____
Varicella #1 _____ ** Rubella _____
Varicella #2 _____ Varicella _____
Tetanus _____

COPY OF MOST RECENT IMMUNIZATION RECORD (WITHIN PAST YEAR) IS BEST SOURCE. PLEASE, ENCLOSE A COPY!

UMassMemorial

Employee Health Services
210 Lincoln Stree, Lower Level
Worcester, MA 01605

Last Name: **First Name:**

M ☐ F ☐ **Date of Birth: / /** **Employee Number/MR #:**

Last 4 digits SS#: **Department:** **Position:**

HISTORY OF POSITIVE TST

COMPLETE THIS FORM IF YOU HAVE A HISTORY OF A POSITIVE TST

•TB infection without active disease is not contagious.

What if I have been vaccinated with BCG?

BCG is a vaccine for TB. This vaccine is often given to infants and small children in other countries where TB is common. If you were vaccinated with BCG, you may have a positive reaction to TST. This reaction may be due to the BCG or a real TB infection. Your health care provider will determine through x-ray and further investigation if you have the real TB infection.

Treatment:
Medication to treat the TB disease is available if the disease is present. The options and course of treatment will be discussed in detail if and when warranted.

If any of the symptoms below occur, and you have a history of a TB exposure or a positive TB test, contact your primary care provider or Employee Health Services.

Symptoms of TB Disease:

☐ Weakness or fatigue ☐ Cough, often coughing up blood ☐ Weight loss
☐ Chills ☐ Night sweats ☐ Fever

Please check applicable boxes in both sections A & B:

A: ☐ I **DO NOT** display any signs and symptoms of TB disease.

OR

☐ I **DO** display what may be symptoms of TB disease. I will immediately follow up with Employee Health Services and my health care provider.

B: ☐ I would like to discuss the option of taking medication to treat inactive TB infection.

Phone # where I can be reached: / /

☐ I have taken medication to treat inactive TB infection. For how long?

☐ I choose not to take medication to treat inactive TB infection.

EMPLOYEE SIGNATURE: **Date: / /**
