MAYO CLINIC

Communicable Disease and Immunization Record

Mayo Clinic College of Medicine Students

Staff Use Only

- ☐ Mayo Graduate School
- ☐ Mayo Medical School
- ☐ Mayo School of Health Sciences
- ☐ Other _____

For the protection of patients, employees, students, volunteers and visitors, and in compliance with state and federal regulations, Mayo Clinic requires immunization against certain vaccine preventable diseases. Mayo Clinic also has a comprehensive plan to reduce the risk of tuberculosis transmission which involves a screening process for all applicants.

Name *(First, Middle, Last)*	Birth Date *(Month DD, YYYY)*
Email Address	Phone

Instructions: Enter the **month/day/year** for **all doses** of **all vaccines**. Note the date and result if you had a serology (blood test) done. In addition, attach health care provider documentation for **all** immunizations.

Remember to complete page 2 of this form.

Vaccine Description	If you have had the vaccination, provide the month/day/year of each vaccination.			If you had a serology (blood test) provide month/date/year and results	
				Test Date	**Test Result**
Hepatitis B	1	2	3		
	4	5	6		
Measles (rubeola, red measles, 7-day measles)	1	2	3		
Mumps	1				
Rubella (German measles, 3-day measles)	1				
or					
MMR (measles, mumps, rubella vaccine)	1	2			
Chicken Pox (varicella)	1	2			
Influenza	1				
DPT (diptheria-pertussis-tetanus)	Have you had your entire primary DPT series? ☐ Yes ☐ No		1		
or					
TD (tetanus-diptheria booster)	1 *(most recent date only)*				
or					
Tdap (adult tetanus-diptheria-pertusis)	1				

Staff Use Only

Vaccines Needed							**Tests Ordered**								Start Date *(Month DD, YYYY)*
HBV			**MMR**		**Tdap**	**TD**	**TST**		**BAMT**	**CXR**	**Anti HBs**	**Rubeola**	**Rubella**	**Varicella**	**Mumps**	
Other Vaccines							Other Tests									End Date *(Month DD, YYYY)*
RN Signature							Date *(Month DD, YYYY)*									

Assessment of Tuberculosis Status (See page 3 for instructions)

Tuberculin Skin Test (TST, Mantoux) Attach written documentation of any TST/chest X-ray results within 15 months of your start date at Mayo Clinic	1st Test Date *(Month DD, YYYY)*	Reaction Size mm	Documentation Provided ☐ Yes
	2nd Test Date *(Month DD, YYYY)*	Reaction Size mm	Documentation Provided ☐ Yes
	If TST is Positive, Last Chest X-ray Date *(Month DD, YYYY)*	Chest X-Ray Results ☐ Negative ☐ Positive	X-Ray Documentation Provided ☐ Yes
Blood Assay Mycobacterium test (Quanti-FERON, Quanti-FERON Gold)	Test Date *(Month DD, YYYY)*	Results ☐ Negative ☐ Positive ☐ Indeterminate	Documentation Provided ☐ Yes
Were you given any medications related to a positive Tuberculin Skin Test? ☐ Yes ☐ No	If yes, list dates *(Month DD, YYYY)*	List medications	

Yes	No	
		1. Do you currently have one or more of the following symptoms? (Check all that apply)
☐	☐	a) a cough that has lasted three or more weeks
☐	☐	b) bloody sputum
☐	☐	c) night sweats
☐	☐	d) weight loss
☐	☐	e) loss of appetite
☐	☐	f) fever
☐	☐	2. Have you ever had a prior "positive" Tuberculin (TB) skin test?
☐	☐	3. Have you been treated for tuberculosis?
☐	☐	4. Have you experienced an ulceration or open weeping sore at the injection site of a prior TB skin test?
☐	☐	5. Do you agree to return to have this test read within the required time of 48 to 72 hours?
☐	☐	6. Do you understand that "self-reading" of the test is not acceptable according to the Center for Disease Control (CDC) guideline?

Assessment of Active Communicable Diseases

Yes	No	
☐	☐	1. Do you have a draining sore or wound?
☐	☐	2. Do you have a skin rash?
☐	☐	3. Have you had any exposure to a contagious disease in the past two weeks?
☐	☐	4. Do you currently have a communicable disease for which you are being treated?

Comments

Signature

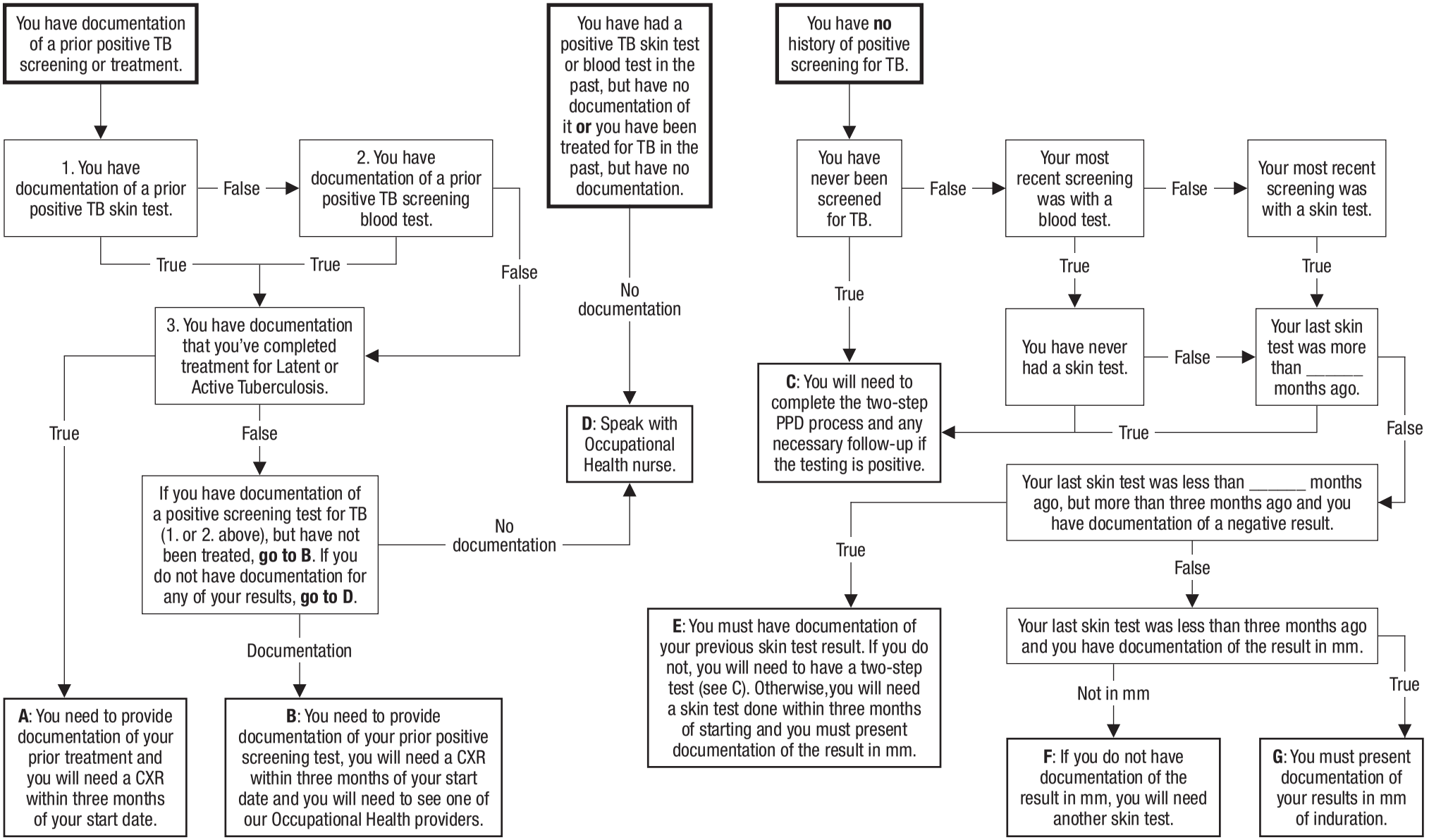
Applicant Signature	Signature Date *(Month DD, YYYY)*

Tuberculin Skin Test Criteria

Below is a map that will assist you with completing the "Assessment of Tuberculosis Status" on page two of your *Communicable Disease and Immunization Record* form. The map guides you through a series of questions which will lead you to the instructions that apply to you.

Tuberculin Skin Testing must be completed by everyone. A Blood Assay or QuantiFERON-TB Blood Test **will not be accepted** unless you are a known positive reactor to TB skin testing. **Documentation of the positive TB skin test with millimeter reading must be provided.**

All TST readings require a numbered mm reading. A negative or positive reading will **not** be accepted.



Instructions

A. You required a **Two-Step Tuberculin Skin Test (TST).**

1. Receive placement of the TST by laboratory personnel.
2. Wait 48-72 hours and return to the lab to have the result of this test read.
3. Wait a minimum of two weeks.
4. Repeat steps one and two.
5. Document test results on *Communicable Disease and Immunization Record* form and enclose an authorized copy of TST results.

B. You required **one additional Tuberculin Skin Test (TST).**

1. Receive placement of the TST by laboratory personnel.
2. Wait 48-72 hours and return to the lab to have the result of this test read.
3. Document test results on *Communicable Disease and Immunization Record* form and enclose an authorized copy of TST results.

C. You require **no further Tuberculin Skin Test (TST).**

1. Document test results on *Communicable Disease and Immunization Record* form and enclose an authorized copy of TST results.

D. You **will require a QuantiFERON-TB blood test completed within six months of your start date or a chest x-ray completed within one year of your start date.**

1. Enclose an authorized copy of the positive TST result and all blood testing or chest x-ray documentation.

E. You **require documentation of both the positive TST result and a chest x-ray** completed within one year of your start date.