Tuberculosis Screening & Questionnaire

As per Health Sciences Program Policy - Clinical Requirements, the result of an annual Tb screening is required to be on file in the Health Sciences office. The Tb Screening Questionnaire is required to be completed as a part of the Tb Screening. Complete this form and have your healthcare provider document the results on the bottom of this form.

STOP! If you have ever had a positive TB test which required you to have a chest x-ray, you must not take further TB tests. Please refer to the Clinical Requirements policy and/or talk with your healthcare provider or Health Services staff for more information.

Name: ____ Age: __________ Date: ______________________________

Student ID#: ___________________ Date of Birth: ________________

Phone #: ______________________________________ Email: ____

Please answer the following questions and check appropriate response:

	YES	NO	Unknown	Year
Have you EVER had a TB (PPD) skin test? If yes, give date				
If yes, was there a reaction?				
Have you been exposed to anyone with **active** tuberculosis?				
Have you ever taken Anti-Tuberculin medications?				
Were you born / lived / traveled outside the U.S.A.?				
Have you had an MMR or chicken pox vaccine in the past 3 months?				
Do you currently have an immune compromised illness?				

Do you currently have any of the following symptoms?

	YES	NO	Unknown
Unexplained fatigue for more than 2 weeks?			
Weight loss (unintentional)?			
Unexplained, persistent cough?			
Cough productive for blood streaked sputum?			
Unexplained fever?			
Night sweats?			

I am at least 18 years of age (under 18 requires written parental consent) and agree to have a

Tuberculosis Screening Skin Test: ____
(Signature)

Date administered: _____________ Result: ☐Positive ☐Negative

Attach a copy of the TB screening administration and interpretation form from your health care provider.