Annual Tuberculosis Screening Form

The following student has a history of a positive TB test (TB Skin Test or T-SPOT, QuantiFERON):

Student Name: _____

Date of positive TB test/Test type: _____

Date of initial chest x-ray: _____

Results of initial chest x-ray: _____

Date of public contact release from health department: _____

Please answer the following questions:

1. Have you had close contact with someone who has had infectious TB disease since your last TB screening test or questionnaire? ☐ Yes ☐ No
2. Do you have a cough that has lasted longer than 3 weeks? ☐ Yes ☐ No
3. Do you experience pain in the chest? ☐ Yes ☐ No
4. Do you cough up blood or thick sputum? ☐ Yes ☐ No
5. Have you had a decrease in your appetite? ☐ Yes ☐ No
6. Have you lost weight (>10 pounds) in the last 2 months without trying? ☐ Yes ☐ No
7. Have you experienced night sweats? ☐ Yes ☐ No
8. Have you had an unexplained, persistent, low-grade fever or chills? ☐ Yes ☐ No
9. Have you experienced weakness or fatigue? ☐ Yes ☐ No

Students that answer "Yes" to any question require further evaluation and assessment by a qualified healthcare provider. Students should not return to campus until re-evaluated and re-released for public contact.

Students must notify the Department Head, Nurse Science if any answer changes prior to their next annual screening.

Student Signature: _____ Date: _____

Based on student documentation and assessment, findings indicate no active disease.

Healthcare Provider Signature: _____ DATE: _____

Healthcare Provider Printed Name: _____