



ANNUAL TB SCREENING FORM

THIS FORM IS FOR STUDENTS WHO PREVIOUSLY HAD A POSITIVE PPD AND COMPLETED A CHEST X-RAY OR ANNUAL TB SCREENING FORM LAST YEAR.

THIS FORM MUST BE COMPLETED AND SUBMITTED BETWEEN JULY 1ST TO JULY 31ST, 2011.

Name: _____ Date of Birth: _____

Date of Birth: ____/____/____ Student ID #: _____ Class of: _____

1. Were you born in the US? YES _____ NO _____
If no, where were you born? _____
2. Have you ever received the BCG (TB vaccine)? YES _____ NO _____
If yes, what year? _____
3. What was the date of your last negative chest x-ray? _____ (Must be 2009 or later)

IN THE PAST 12 MONTHS

4. Have any of your family, friends, or acquaintances been diagnosed with active tuberculosis? YES _____ NO _____
5. Have you traveled out of the country? If yes, where? _____ YES _____ NO _____
6. Have you been around people at risk for TB YES _____ NO _____

SINCE YOUR LAST PPD SCREENING HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

7. Had a cough that lasted longer than 3 weeks? YES _____ NO _____
8. Had a fever that lasted longer than 3 weeks? YES _____ NO _____
9. Coughed up any blood? YES _____ NO _____
10. Had excessive sweating at night? YES _____ NO _____
11. Losing weight without trying to do so? YES _____ NO _____
12. Fatigue? YES _____ NO _____

By signing this form, you declare and certify that the answers you provided are true and accurate.

Student's Signature: _____ Date: _____

Physician's Name (Printed): _____ Clinic/Facility Phone #: _____

Name of Clinic/Facility: _____

Clinic/Facility Address: _____ City: _____ State: _____ Zip: _____

Physician's Signature: _____ Date: _____