



Student Immunization Form Addendum: Tuberculosis Screening Form

If directed to complete a Tuberculosis Screen in Part III: Tuberculosis Self-Questionnaire on the Student Immunization Form, please complete this form and submit to the Office of Undergraduate Admissions **prior to the beginning of your first semester.**

Part I: Screening Results

This MUST be signed by a health care provider (Part II).

Student Name _____ **Date of Birth** _____ **Student ID#** _____

TST	Date Given _____ MM / DD / YY	Date Read _____ MM / DD / YY	Result _____ mm (transverse induration)
QFT-TB	Date Obtained _____ MM / DD / YY	Result: <input type="checkbox"/> Positive (if positive QFT, see interpretation below) <input type="checkbox"/> Negative	
Interpretation (based on mm and induration and risk factors)	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
<i>If positive TST interpretation, obtain QFT</i>	Date Obtained _____ MM / DD / YY	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
<i>If positive QFT result, obtain CXR</i>	Date Obtained _____ MM / DD / YY	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<ul style="list-style-type: none"> • If abnormal, return to Question 1, answer yes. • If normal, initiate INH.
<i>If normal CXR result, initiate INH</i>	Date Initiated _____ MM / DD / YY	Date Completed _____ MM / DD / YY	

Part II: Healthcare Provider (MD, DO, NP or PA) Signature

Printed Name _____ **Telephone** _____

Address _____

Signature _____ **Date** _____