Fill out and take to your health care provider with your immunization record

Tuberculosis Screening: Required of all students

Name _____ Date of Birth: ___/____/_____ Social Security Number: ____–____–____
MM DD YYYY

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Based on the guidelines published by The American College Health Association the recommendations from the Centers of Disease Control (CDC) and the American Thoracic Society, Tuberculosis Screening is required within the last six months primarily by conducting a Risk Assessment. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/. Please answer the following questions. Screening required before entering student teaching.

1. Does the student have **signs or symptoms of active TB disease?** ☐ YES ☐ NO
   If NO, proceed to question 2.

   If YES, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a **high-risk group** or is the student entering the **Health Profession (nursing student)?** ☐ YES ☐ NO

   Categories of high-risk students include those: with HIV infection; who inject drugs; who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone > 15 mg/d for > 1 month) or other immunosuppressive disorders.

   If NO, continue to question 3.

   If YES, place tuberculin skin test (Mantoux only: Inject 0/1 ml of purified Protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] Intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk Group. If PPD is not placed, a chest x-ray is required (see B to record x-ray result)

3. Has the student lived or traveled (spent 6 weeks or more) in countries where TB is endemic? ☐ YES ☐ NO
   Includes those students who have arrived within the past 5 years from countries other than those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

IF NO to #1, #2, & #3, PPD and Chest X-Ray are not required. No further evaluation is required. **PLEASE SIGN BELOW**
IF YES, Students should undergo tuberculin skin test or Chest X-ray. (See #2 Above)

PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY*
*(Based on assessment criteria outlined above)

A. Tuberculin Skin Test
Date given: ____/____/_____ Date read: ____/____/_____ Result: _____mm
MM DD YYYY MM DD YYYY (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors) ☐ Positive ☐ Negative

B. **Chest X-Ray (required if Tuberculin Skin test is positive or if PPD has not been placed but patient is at risk of disease; must have been performed on or after March 1, 2007):** Result: ☐ Normal ☐ Abnormal Date of chest x-ray: a _____
MM/DD/YY
INH Initiated ☐ Date _____X_____months INH course completed ☐ YES ☐ NO

HEALTH CARE PROVIDER: (signature required as validation of correct information for TB assessment only)

Name: _____ Address: _____

Signature: _____ Phone: _____ Date: _____