# 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<br>MM / DD / YY | Date Read<br>MM / DD / YY | Result<br>mm (transverse induration) |
| **QFT-TB** | Date Obtained<br>MM / DD / YY | Result:<br>☐ Positive (if positive QFT, see interpretation below)<br>☐ Negative | |
| **Interpretation**<br>(based on mm and induration and risk factors) | ☐Positive<br>☐Negative | | |
| *If positive TST interpretation,* **obtain QFT** | Date Obtained<br>MM / DD / YY | Result:<br>☐ Positive<br>☐ Negative | |
| *If positive QFT result,* **obtain CXR** | Date Obtained<br>MM / DD / YY | Result:<br>☐Normal<br>☐Abnormal | • If abnormal, return to Question 1, answer yes.<br>• If normal, initiate INH. |
| *If normal CXR result,* **initiate INH** | Date Initiated<br>MM / DD / YY | Date Completed<br>MM / DD / YY | |

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

Printed Name ______________________ Telephone ______________

Address ______________________________________

Signature ______________________ Date ______________