Annual Health Screening Questionnaire for History of Positive TB Skin Test

Instructions: Annual symptom screening is required for all students who have a history of a positive tuberculosis skin test [PPD skin test]. Students are required to see a licensed healthcare provider for symptom screening and completion of this form yearly only if they have a history of a positive TB skin test.

When did you convert to a positive PPD?

What is the date of your last chest x-ray?

Result:

Do you CURRENTLY have symptoms of:

- Weight loss [unrelated to dieting]
- Loss of appetite for > 2 weeks
- Bloody sputum
- Night sweats/fever
- Unusual fatigue for > 2 weeks
- Persistent cough for > 2 weeks

Answering “yes” to any of the above questions constitutes a positive screening evaluation and requires further treatment as recommended by your health care provider.

I am aware that misrepresentation of health information may result in dismissal from the program. I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Signature ____________________________ Date ________________

Print Name ____________________________ Student ID# ________________

Health Care Provider verifying information [THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER]
- Nurse Practitioner, Physician, Registered Nurse, Physician’s Assistant or a public health official-

Name of Health Care Provider [Print] ____________________________ Telephone [area code + number] ____________________________

Signature of Health Care Provider ____________________________ Date ____________________________

Address of Health Care Provider ____________________________

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