HARRIS-STOWE STATE UNIVERSITY
TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

NAME ______________________________ STUDENT ID # ______________________________

DATE OF BIRTH ______________________________

Please answer the following questions:

Yes	No	Have you lived or traveled for >2 months in Asia, Africa, Central or South America or Eastern Europe?
Yes	No	Were you born on one of these continents?
Yes	No	Have you ever been vaccinated with BCG?
Yes	No	Have you ever had a positive TB skin test or history of active tuberculosis infection?
Yes	No	Has anyone living in your household ever had a history of active tuberculosis?
Yes	No	Have you worked or volunteered in a nursing home, hospital, homeless shelter, prison or other health care facility?

If the answer is **NO** to all of the above questions, no further testing or action is required. Please sign below and forward this form with your immunization record to Harris-Stowe Student Health Services A physician's signature is not required on this questionnaire if you answered NO to all the questions.

If the answer is **YES** to any of the above questions, then Harris-Stowe State University requires that a health care provider complete a tuberculosis risk assessment within 6 months prior to the start of class. Results of a tuberculin skin test (PPD) or IGRA blood test such as Quantiferon gold or a T-spot must be provided, unless a previous positive test has been documented. A chest x-ray performed within six months prior to the first day of class is required for a positive PPD or IGRA. A written medical interpretation of the x-ray (in English) must be included.

NOTE: Testing is recommended (but not mandated) for individuals in the following groups:

- HIV positive
- Immunosuppressive disorders from illness or medication (e.g. organ transplants, prednisone)
- History of IV drug abuse or alcoholism
- Students with chronic medical conditions (e.g. diabetes, cancer, kidney disease, malabsorption disorders, etc)

By signing I attest that the above information is true to the best of my knowledge

Student signature: ______________________________ Date: ______________

TB (Tuberculin) Skin Test - Date Administered: ____________ Date Read: ____________ Result: _______mm.

-OR- equivalent blood test result: ________________

Chest X-ray required if TB test is positive: Date: ________ Result: NORMAL ABNORMAL
(Attach written medical interpretation of Chest X-ray in English).

Dates of treatment: ______________________________

Physician/ Clinic name: ______________________________

Physician/ Clinic address: ______________________________

____

Phone number: ______________________________

Physician signature: ______________________________ Date: ____________________

(Physician signature is only required if providing TB test results, blood test results or chest x-ray).