Clark University Health Services
Tuberculosis Screening

Name:_____ Date of Birth:_____ Year Entered:_____
(Last) (First)
Cell Phone: _____ Clark Email: _____ Clark ID #: _____

Address: _____ Country of Birth: _____ Year arrived in US: _____

Please answer the following questions then sign and date the student portion of this form

1. Have you ever had Tuberculosis? ☐ Yes ☐ No
2. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT? ☐ Yes ☐ No
3. Were you born in, lived, worked, or visited for more than 1 month any of the following areas? ☐ Yes ☐ No
   Africa, Asia, Central America, Eastern Europe, South America
   If yes, what country? _____
4. Have you ever had close contact with person(s) known or suspected to have active TB disease? ☐ Yes ☐ No
5. Have you ever been a resident, volunteer, and/or employee in a correctional facility, long-term care facility, hospital or drug rehabilitation unit, or homeless shelter? ☐ Yes ☐ No
6. Have you been diagnosed with HIV infection, AIDS, leukemia, lymphoma, or a chronic immune disorder? ☐ Yes ☐ No
7. Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? ☐ Yes ☐ No

Student signature: _____ Date: ____/____/____

If the answer is **YES** to any of the above questions, you are required to have your healthcare provider complete the information below. If the answer to all questions above is **NO**, no further testing is required.

To be completed by healthcare provider

If patient answered YES to any of the above questions one of the following is required: PPD or QuantiFERON-TG Gold or T-SPOT.

PPD Placed Date: ____/____/____ PPD Reading Date: ____/____/____ Result # of mm induration: _____

-OR-

QuantiFERON-TB Gold or T-SPOT Result Date: ____/____/____ Result (attach lab report): _____

A chest x-ray is required if PPD results are 10mm or more or QuantiFERON-TB Gold or T-SPOT are positive.

Date of chest x-ray: ____/____/____ Result: _____ ☐ Normal ☐ Abnormal

If negative chest x-ray and positive PPD did student complete treatment? ☐ Yes ☐ No ☐ Declined

Prophylactic medications:

Medication Names: _____ Date Started: ____/____/____ Date Completed: ____/____/____

Healthcare Provider Information (Required)

Healthcare provider: _____
Please print (Last) (First) NP, PA, MD, DO

Address: _____

Phone: _____

Signature of Healthcare provider: _____ Date: ____/____/____