**POSITIVE TB READINGS / HISTORY OF POSITIVE (ANNUAL SYMPTOM REVIEW)**

If you have a history of a positive TST or IGRA lab test, please complete the symptom review below. Students with patient contact (clinical/ rotations) and a history of a positive TST or IGRA are to complete this form annually instead annual IGRA/ QuantiFERON Gold.

HX OF BCG **□** Yes **□** No Date if Immunization\_\_\_\_\_\_\_\_\_\_ Last CXR Date\_\_\_\_\_\_\_\_\_\_

**Student to answer the following questions:**

**Symptoms of TB disease**: **Are you experiencing any of the following symptoms?**

Cough, hemoptysis **□** Yes **□** No Fever, chills and/or night sweats **□** Yes **□** No

Shortness of breath **□** Yes **□** No Unexplained weight loss **□** Yes **□** No

Any recent contact with a questionable or known TB positive person? **□** Yes **□** No

If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□** I do not display any signs/symptoms of TB disease.

**□** I do display what may be symptoms of TB disease. I will follow-up with Student Health Services and my

health care provider asap.

I understand that a positive TST or test means that I have been exposed to TB infection but does not necessarily mean I have active TB disease. I understand that TB is spread from person to person through the air if it becomes active disease. The above symptoms may be signs of active TB disease. If I develop these symptoms, I will contact my health care provider asap.

Print Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_