## First-Year Student Tuberculosis Screening Form

## **Student Information**

Full Name
Date of Birth
Student ID
Phone Number
There is taken as a second of the second of
Email Address
Saraaning Quantiana
Screening Questions
Have you ever had a positive TB test?
C Yes C No
If yes, specify date
is yes, specify date
Have you ever been treated for TB?  Yes No
165 V 140
If yes, where and when?
Within the past 12 months, have you traveled or resided in a country with high rates of TB?
C Yes C No
If yes, list countries
Have you had along contact with company diagnosad with TD2
Have you had close contact with someone diagnosed with TB?  O Yes O No
Do you have any of the following symptoms? (check all that apply)
Cough lasting more than 3 weeks
Unexplained weight loss
Fever
Night Sweats
None

Verification		
Student Signature		
Date		
Date		