First-Year Student Tuberculosis Screening Form

Student Information

Full Name

Date of Birth

Student ID

Phone Number

Email Address

Screening Questions

Have you ever had a positive TB test?
Yes No

If yes, specify date

Have you ever been treated for TB?
Yes No

If yes, where and when?

Within the past 12 months, have you traveled or resided in a country with high rates of TB?
Yes No

If yes, list countries

Have you had close contact with someone diagnosed with TB?
Yes 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