Tuberculosis Assessment Form

University of Iowa Student Health & Wellness

Print legibly or use label

Return this Form to:
THE UNIVERSITY OF IOWA
STUDENT HEALTH & WELLNESS
4189 Westlawn South
Iowa City, Iowa 52242 **OR** Fax # 319-335-7247
OR email copy to: immunizations@healthcare.uiowa.edu

Legal Name_____

University ID #_____

MRN _____

Birth Date: Day_____/Month_____/Year_____

Address_____

The purpose of this form is to complete the annual TB assessment health science requirement for individuals that have a history of a positive tuberculosis test.

Do you have any of the following symptoms that are sometimes symptoms of tuberculosis?		
o Chest pain	NO	YES
o Cough that has lasted for 3 weeks or longer	NO	YES
o Coughing up blood	NO	YES
o Fever	NO	YES
o Loss of appetite	NO	YES
o Night sweats	NO	YES
o Unexplained weight loss	NO	YES

If you responded yes, please contact a health care provider for further assessment of your symptoms.

Student Signature _____ Date_____

Student Printed Name_____

Student ID Number _____

Reviewed by: _____(print) Date _____

_____(sign)
(Health Care Provider or Immunizing Official name and credentials)

_____
Current Practice Location name and address

Written: 11/8/13
Revised: