History Of Positive TB Screening Results Form

The purpose of this form is to complete the Health Science Student TB screening requirement for individuals who have a history of a POSITIVE tuberculosis test.

If you are a Health Science student and this is your first time submitting this form complete Section A & Section B.

If you are a Health Science student and need an ANNUAL TB SCREENING for your program or health requirements, complete ONLY Section B.

SECTION A: If “YES” please submit supporting documentation with this form

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a positive TB test result (positive TST or Blood Test)?</td>
<td></td>
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<tr>
<td>Have you ever received a BCG Vaccine?</td>
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<tr>
<td>Have you had a Chest X-ray due to a positive TB test?</td>
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<tr>
<td>Have you been Treated for Active or Latent TB?</td>
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</tbody>
</table>

SECTION B: Do you have any of the following symptoms, if “YES” see your healthcare provider for further assessment

<table>
<thead>
<tr>
<th>Symptom</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain</td>
<td></td>
<td></td>
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<tr>
<td>Cough that has lasted for 3 weeks or longer</td>
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<td></td>
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<tr>
<td>Coughing up blood</td>
<td></td>
<td></td>
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<tr>
<td>Fever</td>
<td></td>
<td></td>
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<tr>
<td>Loss of appetite</td>
<td></td>
<td></td>
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<tr>
<td>Night sweats</td>
<td></td>
<td></td>
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<tr>
<td>Unexplained weight loss</td>
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<td></td>
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<tr>
<td>Have you had any travel out of the country in the past two years?</td>
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<tr>
<td>If “YES”: where, when and length of stay?</td>
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<tr>
<td>Have you had any known contact with anyone with active tuberculosis?</td>
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<tr>
<td>Have you had any high-risk exposures in homeless shelters or prisons?</td>
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<tr>
<td>If “YES”: when was the exposure?</td>
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</tr>
</tbody>
</table>

Student Signature: ______________________________________________________ Date: __________

Reviewed by Health Care Provider (print): ________________________________ Credentials: ______

Reviewed by Health Care Provider (signature): ____________________________ Date: __________

Clinic Name, Address & Phone: OR Clinic Stamp:
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Submit this form/documentation (.pdf scan or photo) or questions to: immunizations@healthcare.uiowa.edu

Written: 11/1819 Reviewed: 4/11/199 Revised: 7/21/20, 12/19/22, 8/1/24