ImmuniTrax

Student Name: _____ Date: _____

Tuberculosis Questionnaire

Please complete the form below if you have ever had a positive reaction to a Tuberculosis Skin Test.

Date of first positive TB skin test:		Measurement:	mm

Have you ever had TB? Yes No

Were you treated with medication? Yes No

Medication name: _____

Length of treatment: _____

Have you ever had BCG? Yes No

Symptoms Review: do you have any of the following?

Chronic cough?	Yes	No
Persistent night sweats?	Yes	No
Chronic fatigue?	Yes	No
Involuntary weight loss?	Yes	No

Are you being treated for any serious medical conditions? Yes No

Please describe: _____

Are you under treatment of Prednisone, Cancer Chemotherapy, or X-Ray Therapy? Yes No

Please describe: _____

Printed Name: _____

Signature: _____

I verify that the above information is correct.

_____ _____

Signature of Physician/ Nurse Practitioner ***Print Name of Physician/ Nurse Practitioner***

Phone: _____ *Address:* _____

City: _____ *State:* _____ *ZIP:* _____

Agency/Clinic Providing Service: _____

This information will be released to hospitals and community agencies where students are placed.