Student Name:_____

TUBERCULOSIS (TB) RISK ASSESSMENT & TEST DOCUMENTATION

SECTION 1: TUBERCULIN (TB) RISK ASSESSMENT Please answer all of the following questions.	**YES**	**NO**
1. Have you lived in or traveled to areas where tuberculosis is common within the last 5 years for 3 months or longer? (Eastern Europe, Asia, Central America, South America, or Africa)		
2. Were you born outside the United States in a country where tuberculosis is common? (Eastern Europe, Asia, Central America, South America, or Africa)		
3. Have you been diagnosed with active tuberculosis?		
4. Have you ever been told you had a positive or reactive TB test?		
5. Have you ever taken medication because of a positive TB test?		
6. Are you experiencing signs or symptoms of tuberculosis? (Productive cough for more than 3 weeks, unexplained weight loss, night sweats &/or persistent fatigue)		
7. Have you had close contact with someone with infectious TB?		
8. Have you lived, worked or volunteered in a long term care facility? (e.g. hospital, prison, nursing home, homeless shelter, or care facility for those with HIV/AIDS)		
9. Have you ever been diagnosed with a chronic condition that may impair your immune system? (e.g. HIV, diabetes, renal failure, leukemia, chemotherapy, severe lung disease)		
10. Do you have HIV or inject drugs?		

1. **If you answered NO to all questions 1-10, no further TB assessment is necessary. Skip SECTION 2: TB TEST DOCUMENTATION and proceed to page 3.**
2. **If you answered YES to questions 3, 4 and/or 5, you must provide documentation of treatment.**
3. **If you answered YES to any questions 1-10, you must take SECTION 2: TB TEST DOCUMENTATION to a health care provider to be completed.**

SECTION 2: TUBERCULIN (TB) TEST DOCUMENTATION

If you answered YES to any question in Section 1: TB Risk Assessment, please take this form to your health care provider or local health department for completion. *Note: BCG vaccination does not preclude TB testing.*

Type of TB Test (Only ONE needed.)

TST (TB Skin Test) ☐	BAMT (TB Blood Test) ☐ or T-Spot (blood test) ☐
Date Administered: Date Read:	Date Drawn:
Reaction in Millimeters: _____mm induration	

Interpretation (based on reaction and risk factors) **Positive ☐** **Negative ☐**

Please provide copy of report. If positive, please provide documentation of follow up care.

Health Care Provider Information

Provider Name: Phone Number:

Provider Signature: Date: