Shasta College

**Health Sciences & University Programs**
***New Student* Tuberculosis Screening & Questionnaire**
**Chest X-Ray / QuantiFERON Gold / Positive PPD**
Last Reviewed 02/25/2019

This form is to be completed if a PPD is positive, if there is a history of positive PPD, or if you elected to receive a QuantiFERON-TB Gold test or chest x-ray instead of a PPD**. *A record of a negative QuantiFERON-TB Gold test within the last year, or a chest x-ray within the past two years must be included*.**

The following questionnaire was developed in collaboration with the Shasta County Health Department, with the intent of reviewing symptoms that might indicate active infection.

| **TO BE COMPLETED BY STUDENT** | Please answer the following questions: (check Yes or No) | |
|---|---|---|
| During the past year, have you experienced any of the following symptoms: | **Yes** | **No** |
| 1. Cough lasting more than 4 weeks and still present? | ☐ | ☐ |
| 2. Cough that brings up thick mucus from the lower chest? | ☐ | ☐ |
| If yes, does the mucus ever have blood in it? | ☐ | ☐ |
| 3. Unexplained night sweats in which linens or bed clothes are wet and not related to environmental temperatures? | ☐ | ☐ |
| 4. Unexplained feeling of weakness or fatigue lasting longer than 4 weeks? | ☐ | ☐ |
| 5. Unexplained weight loss of 5-10 pounds? | ☐ | ☐ |
| 6. Unexplained low grade fever, on and off, lasting longer than 4 weeks? | ☐ | ☐ |

I certify that the above information is true and complete. I understand that any misrepresentation or omission of facts may result in program ineligibility or dismissal from the program.

_____ (Student Name Printed) _____ (Student Signature) _____ (Date)

***Please see your primary care provider (PCP) for completion of the following section and evaluation of any symptoms consistent with possible Tuberculosis.***

**TO BE COMPLETED BY PRIMARY CARE PROVIDER**

**MEDICAL EXAMINATION**

The following examinations were completed to rule out active (contagious) tuberculosis:

[ ] Physical Exam Date _____ [ ] QuantiFERON-TB Gold Date _____
[ ] Chest X-ray Date _____ [ ] Sputum Date _____

☐ My examination of this individual **does not** reveal communicable disease that could create a hazard to others. He/she may participate in class and clinical experiences.

☐ My examination of this individual **does** reveal communicable disease that could create a hazard to others.
☐ I have notified the Shasta County Health Department of my findings.

The following treatment was initiated on _____ (date).

Name of Medication _____ Duration of Treatment _____

He/she may return to class and participate in clinical experiences on _____ (date).

*****A statement of findings/interpretation and a letter of clearance to participate in class & clinical experiences is attached. *****

_____ (PCP Name Printed) _____ (PCP Signature) _____ (Date)

**PLEASE RETURN THIS QUESTIONNAIRE TO THE HEALTH SCIENCES OFFICE**