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

This form is to be completed 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 five 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 by checking: (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) _______________________ (Signature) ____________ (Date)

If you answered "yes" to any of the above questions, please see your primary care provider (PCP) for evaluation of symptoms consistent with possible Tuberculosis and have the section below completed by your PCP.

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