For Resident Hall Students ONLY

Name_______________________________________ DOB ______/_____/_____

TUBERCULOSIS (TB) SCREENING/TESTING (REQUIRED)

Please answer the following questions:

Has anyone in your family or other close contact had tuberculosis (TB)?
YES NO

Have you ever had a positive TB test?
YES NO

Have you ever been on medication to treat TB?
YES NO

If yes, did you complete the treatment? _______yes _____no
*Have you ever spent more than two months outside of the United States?
YES NO
If yes, when? ____
Please list the country(s) in which you resided _______________________________
International students: Have you ever had a Bacilla Calmette-Guerin (BCG) vaccine
YES NO

*In what country were you born? ____

Have you ever worked or volunteered in a prison/jail?
YES NO

Have you ever provided patient care in a nursing home, hospital or other health care facility?
YES NO

Have you ever worked or volunteered in a residential facility for patients with AIDS?
YES NO

**Significance of travel exposure and/or country of origin should be discussed with a health care provider.*

Check if you have any symptoms listed below: