Colgate University Health Services
Required Tuberculosis (TB) Screening

Part II TO BE COMPLETED ONLY IF STUDENT ANSWERED YES TO ANY OF THE 5 QUESTIONS ON PART I SECTION B

Student Name: ____________________________ DOB _____/_____/_____
(PLEASE PRINT) Last Name First Name M.I.

Medical practitioner:
- Screening must be done within 6 months of the first day of classes.
- A student who has any positive risk factors must be tested for TB infection if there is no written documentation of a previous positive tuberculin skin test (TST) or Interferon gamma release assay (IGRA) (e.g. T-Spot, Quantiferon Gold).
- Previous BCG Immunization does not change TB screening requirements.

1. TB Symptom Check
Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☐ No

If no, proceed to 2 or 3.
If yes, check below and proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
☐ Coughing up blood (hemoptysis)
☐ Chest pain
☐ Loss of appetite
☐ Unexplained weight loss
☐ Night sweats
☐ Fever

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write “0”. The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: _____/____/_____ Date Read: _____/____/_____
Result: ________ mm of induration **Interpretation:
positive____ negative____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: _____/____/_____ (QFT-GIT, T-Spot)
Result: negative____ positive____ indeterminate____ borderline____ (T-Spot only)

4. Chest x-ray (Required if TST or IGRA is positive)

Date Obtained: _____/____/_____
Result: normal ____ abnormal ____

5. Please indicate any treatment given for positive TB testing: __________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Health care provider (M.D., D.O., P.A., N.P., R.N., school health professional, health official) verifying the above must sign below.

Name (please print): ____________________________
Signature: ____________________________ Title: ____________________________ Date: ____________________________
Address: ____________________________ Phone: ____________________________ Fax: ____________________________

SIGN HERE