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

2. Tuberculin Skin Test (TST)** http://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm

(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