**2021 MANDATORY TUBERCULOSIS SCREENING FORM NV Enterprises Training Academy**

371 McDonough Pkwy, McDonough, GA 30253

Phone: 770-957-1558

Name (please print): \_\_\_ Student #:

Last First MI

Country of Birth: Year arrived in US:

**MANDATORY TUBERCULOSIS SCREENING FORM**

*Sections A and B are REQUIRED for ALL Students*

**SECTION A: History of Tuberculosis (TB)?**

1. Have you ever been sick with tuberculosis? **YES 􀂆 NO 􀂆**

2. Have you ever had a positive PPD, TB QuantiFERON test, or T-SPOT? **YES 􀂆 NO 􀂆**

**SECTION B: At Risk for Tuberculosis (TB)?**

1. **Are you currently in a health-related academic program/major?** **YES 􀂆 NO 􀂆**
2. Were you born in, or have you lived, worked, or visited for more than one month in any of the following:

Asia, Africa, South America, Central America, or Eastern Europe? **YES 􀂆 NO 􀂆**

If yes, what country? How long?

Reason (please circle) Born there Tourist Work School other \_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had HIV infection, AIDS, diabetes, leukemia, lymphoma or a chronic immune disorder? **YES 􀂆 NO 􀂆**
2. Do any of the following conditions or situations apply to you?
   1. Do you have a persistent cough? (3 weeks or more), fever, night sweats, fatigue, loss of appetite,

or weight loss? **YES 􀂆 NO 􀂆**

* 1. Have you ever lived with or been in close contact to a person known or suspected of being sick?

with TB? **YES 􀂆 NO 􀂆**

* 1. Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or?

drug rehabilitation unit, nursing home or residential healthcare facility? **YES 􀂆 NO 􀂆**

Student Signature Date \_\_\_\_\_\_

If you answered no to all the above questions, skip Section C.

***If you answered yes to any of the above questions, your health care provider must complete Section C below.***

**SECTION C: ATTENTION HEALTH CARE PROVIDER:** If student answered YES to any of the above questions, proof of a PPD, QuantiFERON –TB Gold or T-SPOT is REQUIRED. If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT are positive a chest x-ray is REQUIRED. Testing and/or chest x-ray must be done within one calendar year prior to admittance (unless history of positive PPD). If student has history of positive PPD, chest x-ray is required. History of BCG vaccination does not prevent testing of a member of a high-risk group.

PPD: Date placed Date read # of mm induration.

Exp. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ Lot# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

QuantiFERON-TB Gold or T-SPOT: Result Date Result (attach lab report)

Date of chest x-ray Result

**If negative CXR and positive PPD, did student complete a course of INH? YES 􀂆 NO 􀂆**

**If yes, when**   **(months & year) and for how many months did student take INH?**  (# **of months)**

**PROVIDER INFORMATION REQUIRED**

Signature/Stamp of Health Care Provider Phone number of practice Date