Annual TB Symptom Screening Form

History of Positive TB

This form should only be completed if you have a **history of positive TB** (i.e., tested positive on a previous TB screening test) and you're considered current or returning student.

Student Information

Legal First and Last Name: _____ **DOB:** _____

Select One:

☐ I am a current student

☐ My last experience concluded less than 180 days ago (returning student)

Tuberculosis Symptom Questionnaire

This section must be completed by the student.

In the past year, have you experienced any of the following symptoms NOT associated with a specific illness (i.e. cold or flu) and lasting more than 3 weeks?

Symptom	NO	YES	Comments
Cough	☐	☐	
Blood streaked sputum	☐	☐	
Unexplained weight loss	☐	☐	
Night sweats (*excluding menopause*)	☐	☐	
Fever	☐	☐	

By signing below I certify that all of the above selections are true.

Student Signature **Today's Date**