

\_\_\_\_\_  
Last Name, First Name

\_\_\_\_\_  
Date of Birth

Wellness Center

**TUBERCULOSIS SCREENING**

**TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY**

Tuberculosis screening is required of all students entering Dickinson College, based upon guidelines of the American College Health Association and the U.S. Centers for Disease Control. For more information, see [www.acha.org](http://www.acha.org) or [www.cdc.gov/tb](http://www.cdc.gov/tb).

**Tuberculosis (TB) Risk Assessment**

1.	Does the student have signs or symptoms of active tuberculosis disease? • Unexplained elevation of temperature for more than one week, weight loss, night sweats, persistent cough for more than 3 weeks or cough with production of bloody sputum (hemoptysis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Has the student ever had a positive Tuberculin Skin Test (TST) or Quantiferon (QFT) or TB-spot blood test?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Is the student a member of a high risk group that may have increased incidence of latent <i>M. tuberculosis</i> infection or active tuberculosis? • Had close contact with a known case of active tuberculosis • From a medically underserved or low-income area • Currently on immunosuppressive therapy • Abuse of drugs or alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Does the student have a medical condition associated with increased risk of progressing to TB disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Has the student lived, traveled or had frequent or prolonged visits (more than 1 month) within the past 5 years to any of the countries in the table below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**TABLE OF COUNTRIES ENDEMIC FOR TUBERCULOSIS**

Afghanistan	Cambodia	Ethiopia	Kuwait	Morocco	Rep Moldova	Tunisia
Algeria	Cameroon	Fiji	Kyrgyzstan	Mozambique	Romania	Turkmenistan
Angola	Central African Republic	Gabon	Lao PDR	Myanmar	Russian Federation	Tuvulu
Anguilla	Chad	Gambia	Latvia	Namibia	Rwanda	Uganda
Argentina	China	Georgia	Lesotho	Nauru	Sao Tome and Principe	Ukraine
Armenia	China, Hong Kong SAR	Ghana	Liberia	Nepal	Senegal	UR Tanzania
Azerbaijan	China, Macao SAR	Greenland	Libya	Nicaragua	Sierra Leone	Uruguay
Bangladesh	Colombia	Guam	Lithuania	Niger	Singapore	Uzbekistan
Belarus	Comoros	Guatemala	Madagascar	Nigeria	Solomon Islands	Vanuatu
Belize	Congo	Guinea	Malawi	Niue	Somalia	Venezuela
Benin	Cote d'Ivoire	Guinea-Bissau	Malaysia	Northern Mariana Islands	South Africa	Viet Nam
Bhutan	DPR Korea	Guyana	Maldives	Pakistan	South Sudan	Yemen
Bolivia	DR Congo	Haiti	Mali	Palau	Sri Lanka	Zambia
Bosnia and Herzegovina	Djibouti	Honduras	Malta	Panama	Sudan	Zimbabwe
Botswana	Dominican Republic	India	Marshall Islands	Papua New Guinea	Suriname	
Brazil	Ecuador	Indonesia	Mauritania	Paraguay	Tajikistan	
Brunei Darussalam	El Salvador	Iraq	Mauritania	Peru	Thailand	
Burkina Faso	Equatorial Guinea	Kazakhstan	Mexico	Philippines	Timore-Leste	
Burundi	Eritrea	Kenya	Micronesia	Qatar	Togo	
Cabo Verde	Eswatini	Kiribati	Mongolia	Rep Korea	Tokelau	

**If answered NO to all above answers, student does not meet high-risk criteria and further testing is not needed. If answered yes to any of the above questions, the student does meet high-risk criteria and is required to undergo tuberculosis screening.**

If YES, provide documentation of evaluation to exclude active tuberculosis disease, including tuberculosis testing, chest x-ray, and sputum evaluation, as indicated. **Date of testing must be 6 months from start of classes.**

Previous Negative Tuberculosis Testing: <b>Tuberculin Skin Test (TST):</b> <i>TST results must be read in 48-72 hours following the test and should be recorded as actual millimeters (MM) of induration, transverse diameter; if no induration, write "0".</i>  Date Placed _____ Date Read _____ Results: ____mm	Previous Positive Tuberculosis Testing or BCG Inoculation: <b>Quantiferon Test (QFT) or T-Spot blood test:</b> <b><u>A copy of the lab report must be provided in English.</u></b>  Date obtained _____ Results:
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**If testing is positive, a chest x-ray is required and a report must be provided in English.**

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number