University of South Dakota Health Affairs

TUBERCULOSIS RISK ASSESSMENT & ANNUAL SYMPTOM CHECKLIST FOR TUBERCULOSIS

Upon admission, students are required to complete this form which will be reviewed by USD Student Health Services. Annually, students are required to complete the signs and symptoms review, as well as the TB education attestation.

Student's Name (Print):_____ Student's Program:_____

TB RISK ASSESSMENT:	**YES**	**NO**
Temporary or permanent residence (for ≥1 month) in a country with a high TB rate (i.e., any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)	☐	☐
Current or planned immunosuppression, including human immunodeficiency virus infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication TNF = tumor necrosis factor	☐	☐
Close contact with someone who has had infectious TB disease since the last TB test	☐	☐
SIGNS & SYMPTOMS REVIEW: *In the last year have you experienced any of the following symptoms for more than three weeks at a time?*	**YES**	**NO**
Persistent cough, lasting more than 3 weeks	☐	☐
Excessive sweating at night	☐	☐
Unexplained, sudden weight loss	☐	☐
Coughing up blood	☐	☐
Chest pain	☐	☐
Shortness of breath or difficulty breathing	☐	☐
Unexplained fatigue lasting more than 3 days	☐	☐
Unexplained fever lasting more than 3 days	☐	☐
Other S/S or known TB exposure (describe):_____	☐	☐

I (student) have reviewed and understand CDC's TB facts sheet https://www.cdc.gov/tb/publications/factsheets/default.htm and have no questions about TB risk factors, signs and symptoms of TB, nor USD's infection control policies or procedures. ☐ YES ☐ NO (Check appropriate answer.)

_____ _____

Student's Signature Date

_____ _____

Nurse's Signature Date

If student has a history of latent TB proceed to the next page, if not circle: N/A

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LATENT TUBERCULOSIS INFECTON

Student's Name (Print):_____ Student's Program:_____

Date:_____

Positive TB skin test (if applicable): Date:_____ Reading (in mm)_____

Interferon-gamma release assay (Quantiferon or similar, if applicable): Date_____ Results _____

Date of last chest x-ray_____

Chest x-ray results_____

Prophylactic treatment received? If yes; drug, dosage, and date of treatment or statement from PCP/provider that treatment was completed:

_____

_____

_____

I (student) have reviewed and understand CDC's TB facts sheet https://www.cdc.gov/tb/publications/factsheets/default.htm and have no questions about TB risk factors, signs and symptoms of TB, nor USD's infection control policies or procedures. ☐ YES ☐ NO (Check appropriate answer.)

_____ _____

Student's Signature Date

_____ _____

Nurse's Signature Date