

# 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: \_\_\_\_\_

<b>TB RISK ASSESSMENT:</b>	<b>YES</b>	<b>NO</b>
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		
<b>SIGNS &amp; SYMPTOMS REVIEW:</b> <i>In the last year have you experienced any of the following symptoms for more than three weeks at a time?</i>	<b>YES</b>	<b>NO</b>
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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University of South Dakota Health Affairs  
LATENT TUBERCULOSIS INFECTION

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