Samford University
Moffett & Sanders School of Nursing

IMMUNIZATION RECORD

Required of all Moffett & Sanders School of Nursing Students

Patient _____
LAST *FIRST* *MI*

TUBERCULOSIS SCREENING:

The Moffett & Sanders School of Nursing at Samford University requires a two-step Tuberculosis skin test (TST), or an IGRA blood test for all students within 6 months of the published compliance deadline. If you have received the BCG vaccine, an IGRA blood test is preferred. If you have a history of a positive Tuberculosis skin test (TST) ≥10mm or positive IGRA blood test please supply information regarding any evaluation and/or treatment below. Guidelines are based upon the recommendation for Tuberculosis screening for healthcare providers by the CDC. Tuberculosis screening must be completed within 6 months prior to the beginning of clinical rotations.

The two-step Tuberculosis skin test requires 4 separate appointments and must be administered between one (1) and three (3) weeks apart.

Section A		**Date Placed**	**Date Read**	**Reading**
Must be completed by all students with no prior history of Tuberculosis, prior positive TST or positive IGRA blood test	TST #1	____/____/____	____/____/____	____ mm
	TST #2	____/____/____	____/____/____	____ mm
	IGRA Blood Test □ T-spot □ Quantiferon Gold		□ Attach copy	

Section B		**Date Placed**	**Date Read**	**Reading**
Only completed by students with a history of Latent Tuberculosis, Positive 2-step TST, or positive IGRA blood test	Positive TST	____/____/____	____/____/____	____ mm
	Positive IGRA Blood Test	**Date** ____/____/____	**Type Test** □ T-spot □ Quantiferon Gold	□ Attach copy
	Chest X-ray	____/____/____	□ Attach copy	
	Prophylactic medications for latent TB taken?		□ Yes □ No	
	Total duration of prophylaxis?		____ months	
	Date of last annual TB symptom questionnaire (if applicable)		____/____/____	

Section C			
Only completed by students with a history of active tuberculosis	Date of Diagnosis	____/____/____	□ Attach copy
	Date Treatment Completed	____/____/____	□ Attach copy
	Date of last annual TB symptom questionnaire (if applicable)	____/____/____	□ Attach copy
	Date of last Chest X-ray	____/____/____	□ Attach copy

MD/DO/PA/NP/CRNP/RN/LPN Signature: _____ **Date:** _____

Licensed Healthcare Provider's Printed Name and Credentials: _____

Facility Name and Address: _____

City: _____ State: _____ Zip Code: _____ Phone: (____) _____-_____

Tuberculosis screening form must be completed and signed by a health care provider (MD, DO, NP/CRNP, PA, RN) and uploaded by the student to their compliance account.