College of Health Sciences

TB IMMUNIZATION RECORD

For Returning Students Only

Name: _____ **SU ID:** __ __ __ __ __ __ __ __ __

Last *First* *MI*

Email address: _____ **Date of Birth:** _____/_____/_____

Phone number: (_____) _____-_____

Enrolling: ☐Fall☐ Jan Term☐ Spring☐ Summer of Year 20___ **Program of Study:** _____

Living in Campus Housing? Yes [ ] No [ ]

TUBERCULOSIS SCREENING (student must answer BOTH screening questions)

1. Does the student have signs or symptoms of active tuberculosis disease? (Symptoms include: persistent, coughing up blood, fever, fatigue, unexplained weight loss, etc.)

Yes [ ] No [ ] **If No, proceed to 2. If yes, proceed to #3** for additional evaluation to exclude active tuberculosis disease.

2. Is the student a member of a high risk group or is the student entering a health profession? Yes [ ] No [ ] **If No, stop**. **If yes, proceed to #3 below**.

-**High risk students include** those who have arrived within the past 5 years from any foreign country EXCEPT: Western Europe, Canada, Australia or New Zealand. Additional high-risk categories include those with HIV infection or other immunosuppressive disorders, h/o IV drug use, or those who have resided in, or worked in high-risk congregate settings such as prisons, shelters, hospitals, nursing homes, etc.
-**Also includes** students currently working in a healthcare setting or entering into the clinical portion of a health profession field of study; does not include pre-requisite courses

3. If the student answers **'yes' to either of the questions above**, please proceed with the Tuberculosis screening:

a. PPD Skin Test (Mantoux):
Date Given: _____ Date Read: _____ Results: (mm induration) _____ **If positive, report to Health Department for further evaluation (chest x-ray and IGRA)**
month/day/year month/day/year

OR

b. IGRA (Quantiferon gold or T-spot) accepted in lieu of TB Skin test within 6 months of entrance **for students with history of positive TB Skin test**. - Must provide copy of lab report, chest x-ray report of negative findings, and the Samford TB questionnaire.
Result _____ Date _____

OR

c. Chest x-ray (required **if student has history of latent or active TB disease***) -Date of Chest x-ray (must be within 6 months of entrance): _____ -Results: Normal [ ] Abnormal [ ] -Must attach documentation of treatment, chest x-ray report, and TB questionnaire.

MD/PA/NP Signature: _____ Date: _____ within 6 months of entrance

Print Name: _____ Phone: (_____) _____-_____

Address: _____

RETURN COMPLETED FORM TO: COLLEGE OF HEALTH SCIENCES – upload via ESS @www.Es2.com

NOTE: This form is only for CHS students returning to Samford. New students/Transfer students must provide the complete TB and Immunization Form.