UNMC STUDENT HEALTH
Annual Tuberculosis Review Form

Please upload and submit to your Student Health Immunization page.

Last Name:_____ **First Name:** _____

Last 4 digits of Social Security Number: _____ **Date of Birth:** _____

Program: _____

Part 1

Have you ever received the BCG vaccine? ☐ No ☐ Yes

If yes, when? _____

Have you EVER test positive to the TB skin test? ☐ No ☐ Yes

If yes, when? _____

Date of **most recent** chest x-ray: _____

Results: _____

Treatment for latent TB? ☐ No ☐ Yes

Dates of treatment: _____

Do you have any of the following:

Persistent cough?	☐ No ☐ Yes
Sputum?	☐ No ☐ Yes
Unexplained weight loss?	☐ No ☐ Yes
Prolonged fevers?	☐ No ☐ Yes
Night sweats?	☐ No ☐ Yes
Undue fatigue?	☐ No ☐ Yes

***Complete part 2 if you answered yes to any question in part 1.**

Part 2

Tobacco history? ☐ No ☐ Yes ____ packs/day ____ years

Current smoker ☐ No ☐ Yes ____ packs/day

Current steroid use? ☐ No ☐ Yes Dose: _____

Current lung disorder? ☐ No ☐ Yes

FOR STAFF USE ONLY: FOR DOCUMENTATION OF PPD RESULTS

MUST BE READ 48-72 HOURS AFTER GIVEN

Date Placed: _____

LOT **EXP:** _____

Site: **LEFT FOREARM** _____ **RIGHT FOREARM** _____

Placed By: _____

Date Read:_____

Result: _____mm (i.e.: 0mm indurations)

Read By:_____

I have read the information on this form. I understand the benefits and risks, and accept responsibility for any complications resulting from receiving the vaccine. I authorize Student Health to report my immunization status to my designated coordinator and/or the Department of Epidemiology, I agree to have my vaccination information logged for tracking purposes.

Student Signature: _____

Date: _____