Name: _____ Social Security Number: _____

TUBERCULOSIS QUESTIONNAIRE
(MANDATORY – NO EXEMPTIONS)

****

Have you ever had a positive PPD skin test in the past? **YES** **NO**

If yes, **STOP**. *Please submit evidence of treatment or if you have no evidence of treatment, please obtain QuantiFERON-TB Gold (QFT) or T-Spot blood test. If QFT or T-Spot is positive, please obtain a chest x-ray.* ____ ____

****

PAST HISTORY

	YES	NO
1. Were you born in, have you ever lived in, or recently traveled to (within the past 5 years) any country in the following areas of the world? *Africa, Asia, Caribbean nations, Central America (including Mexico), Eastern Europe, India and other Indian Subcontinent Nations, Middle East, Portugal, South America, South Pacific (except Australia and New Zealand), or Spain*	____	____
2. Do you have a history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use?	____	____
3. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility?	____	____
4. Do you have AIDS/HIV or take immunosuppressive medication such as prednisone?	____	____
5. Have you been in close contact with someone with TB?	____	____

IMPORTANT: If you have answered "YES" to any of the above 5 questions listed under PAST HISTORY, you are required to have a PPD skin test within the past year. You can obtain the PPD skin test from your physician or student health center.

NOTE TO HEALTH CARE PROVIDERS: Please record the size of the induration in millimeters. If there is no reaction, please record as "0 mm". **Students who have had a BCG vaccine are still required to have a PPD skin test**. If the screening skin test is positive (10mm or greater for those who answer "YES" to questions 1, 2, or 3, and 5mm or greater for those who answer "YES" to questions 4 or 5), we require the QuantiFERON-TB Gold (QFT) or T-Spot blood test to confirm the student has actually been exposed to TB in the past. (A chest x-ray is required if either test is positive.) **PLEASE FOLLOW THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES FOR THE TREATMENT OF LATENT TUBERCULOSIS INFECTION (LTBI) – SEE WWW.CDC.GOV.**

Date PPD Applied: _____ Date PPD Read: _____ Size of Induration: _____ mm

Date of QFT or T-Spot (circle type): _____ Result: Negative_____ Positive_____ **(provide copy of result)**

Date of Chest X-ray: _____ Result: Normal_____ Abnormal_____

Name of Medication: _____ Date Initiated: _____

Health Care Provider's Name, Address, tele #: _____

Health Care Provider's Signature: _____

****REMEMBER! You will not be eligible to pay University fees until all immunization records are in compliance or the exemption is signed.**

RETURN THIS FORM TO:

Foster-Johnson Health Center
403 Main St., Box 4251
Grambling, LA 71245
(318) 274-2351 (phone)
(318) 274-2481 (fax)
www.gram.edu

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