Georgia Tech Stamps Health Services Campus Services

TUBERCULOSIS (TB) ASSESSMENT FORM (REQUIRED)
US/CANADIAN BORN STUDENTS ONLY

Please upload completed form at www.immunizations.health.gatech.edu.

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

All international born students must receive a QuantiFERON test.

Semester Beginning: _____ Country of Birth: _____

GT ID#: _____ Birth Date: _____ Cell Phone #: _____ Email: _____

Name (Last, First, Middle) _____

Address: _____ City:_____ State: _____ Zip Code: _____ Country: _____

INSTRUCTIONS TO PROVIDER

TB assessment must be done within six (6) months prior to start of classes**.** PLEASE NOTE: TB skin tests, TB assessment and chest x-rays conducted outside of the United States of America or Canada will NOT be accepted under any circumstances. **If at risk, a tuberculin skin test or tuberculosis blood test (Quantiferon or T-Spot accepted) must be completed within 6 months prior to the first day of class.**

History:

1. Have you ever had a positive test for tuberculosis (blood or skin test)? ☐ **No** ☐ **Yes** If so, date of test: _____
2. Did you take medication(s) for the positive test**?** ☐ **No** ☐ **Yes**
   If yes, please list dates of treatment and medication taken: _____
3. Have your ever received a BCG (Bacillus Calmette–Guérin) vaccine? ☐ **No** ☐ **Yes** If yes, QuantiFERON test recommended.

If student has had a positive tuberculosis test in the past, the student will need a chest x-ray done no more than 6 months prior to the first day of class. An official report of the chest x-ray results will need to be uploaded. Chest x-rays performed outside of the United States or Canada will NOT be accepted.

Symptom Risk: Do you currently have any of the following symptoms?				**Symptom risk present?** (any question to the left answered yes) ☐ No ☐ Yes
3 weeks or more of Persistent Cough?	☐ No ☐ Yes	Unexplained weight loss?	☐ No ☐ Yes	
Persistent Fever or Chills?	☐ No ☐ Yes	Persistent Night Sweats	☐ No ☐ Yes	
Loss of Appetite?	☐ No ☐ Yes	Coughing up blood?	☐ No ☐ Yes	
Exposure Risk: Have you lived, worked, or volunteered in the following types of facilities?				**Exposure risk present?** (any question to the left answered yes) ☐ No ☐ Yes
Hospital?	☐ No ☐ Yes	Prison?	☐ No ☐ Yes	
Homeless Shelter	☐ No ☐ Yes	Nursing Home?	☐ No ☐ Yes	
Long Term Care Facility?	☐ No ☐ Yes	Residential Facility for patients with AIDS?	☐ No ☐ Yes	
Rehabilitation Facility?	☐ No ☐ Yes	Had contact with a person known to have TB?	☐ No ☐ Yes	
Travel Risks:				**Travel risk present?** (Yes to the question on the left) ☐ No ☐ Yes
Have you had frequent or prolonged visits to one or more of the countries or territories listed below with a moderate or high prevalence of TB disease?			☐ No ☐ Yes	
Countries traveled or lived in:				

If the student has any one of the risks in the right hand column above marked YES they will need a TB skin test (PPD) or a QuantiFERON test done.

CERTIFICATION OF HEALTHCARE PROVIDER AND DATE REQUIRED

Is this student at risk for TB Exposure? (One or more risk(s) in the right hand column of the table above present)

☐ **YES** (complete TB Skin Testing Form) ☐ **NO**

Provider Name: _____ Date: _____ Phone # _____

Signature: _____