

For Resident Hall Students ONLY

Name	DOB/
TUBERCULOSIS (TB) SCREE Please answer the following quest	ENING/TESTING (REQUIRED) tions:
Has anyone in your family or othe YES NO	er close contact had tuberculosis (TB)?
Have you ever had a positive TB tYES NO	test?
Have you ever been on medication YES NO	n to treat TB?
*Have you ever spent more than t YES NO	ne treatment?yesno ewo months outside of the United States?
Please list the country(s) in which	h you residedever had a Bacilla Calmette-Guerin (BCG) vaccine
*In what country were you born?	
Have you ever worked or volunted YES NO	ered in a prison/jail?
Have you ever provided patient ca YES NO	are in a nursing home, hospital or other health care facility?
Have you ever worked or volunted YES NO	ered in a residential facility for patients with AIDS?
*Significance of travel exposure a provider.	and/or country of origin should be discussed with a health care
Check if you have any symptoms	listed below: