Printed Student Name: ____ Date of Birth: _______________________

TUBERCULOSIS is an illness in which TB bacteria are multiplying and attacking a part of the body, usually the lungs The symptoms of TB disease include weakness, weight loss, fever, no appetite, chills, and sweating at night. Other symptoms of TB disease depend on where in the body the bacteria are growing. If TB disease is in the lungs (pulmonary TB), the symptoms may include a bad cough, pain in the chest, or coughing up blood. A person with TB disease may be infectious and spread TB bacteria to others. (CDC, March 21, 2016)

TUBERCULOSIS SCREENING

Tuberculin Skin Testing is only required of students who fit one of the two categories for high risk listed below. Read the information on the two categories and then indicate whether you are a student at risk for tuberculosis.

Category 1: Students who have arrived within the past five years from countries where TB is endemic are at risk for tuberculosis. **TB IS ENDEMIC IN ALL COUNTRIES EXCEPT THE FOLLOWING**: USA, American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, San Marino, Sweden, Switzerland, United Kingdom and US Virgin Islands.

Category 2: Students who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or luymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy or HIV infections or other immunosuppressive disorders.

____ I verify that I **DO NOT** fit into either of these categories.

____ I verify that I **DO** fit into one of these categories and will complete the following requirements.

____ I have received BCG.

____ PPD Test Date Administered _________________ Date Read __________________

Results __________ Provider Signature ____

*If PPD positive or you have received BCG, chest xray or lab test results ____________________

*If chest xray or lab test positive, please submit treatment plan from home physician.

Student Signature ____ Date _________________

If Student is under 18, parent/guardian signature ___________________________________ Date _____________

Please return all documentation to:

Mail: Toccoa Falls College OR Email: health@tfc.edu OR Fax: (706) 282-6026
Student Health Services
107 Kincaid Dr. MSC 787
Toccoa Falls, GA 30598

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