IOWA | Student Health

Date: _____

Student Name:_____

University ID Number:_____

Date of Birth: Month_____ Day _____ Year_____

History Of Positive TB Screening Results Form

The purpose of this form is to complete the Health Science Student TB screening requirement for individuals who have a history of a POSITIVE tuberculosis test

If you are a *Health Science* student and this is your **first time** submitting this form complete **Section A** & **Section B.**

If you are a *Health Science* student and need an **ANNUAL TB SCREENING** for your program or health requirements, complete ONLY **Section B**.

SECTION A:	**If "YES" please submit supporting documentation with this form**	
Have you ever had a positive TB test result (positive TST or Blood Test)?	☐ YES	☐ NO
Have you ever received a BCG Vaccine?	☐ YES	☐ NO
Have you had a Chest X-ray due to a positive TB test?	☐ YES	☐ NO
Have you been Treated for Active or Latent TB?	☐ YES	☐ NO

SECTION B:	**Do you have any of the following symptoms, if "YES" see your healthcare provider for further assessment**	
Chest Pain	☐ YES	☐ NO
Cough that has lasted for 3 weeks or longer	☐ YES	☐ NO
Coughing up blood	☐ YES	☐ NO
Fever	☐ YES	☐ NO
Loss of appetite	☐ YES	☐ NO
Night sweats	☐ YES	☐ NO
Unexplained weight loss	☐ YES	☐ NO
Have you had any travel out of the country in the past two years?	☐ YES	☐ NO
*If "YES": where, when and length of stay?*_____		
Have you had any known contact with anyone with active tuberculosis?	☐ YES	☐ NO
Have you had any high-risk exposures in homeless shelters or prisons?	☐ YES	☐ NO
If "YES": when was the exposure? _____		

Student Signature:_____ **Date:**_____

Reviewed by Health Care Provider (print): _____ **Credentials:**_____

Reviewed by Health Care Provider (signature): _____ **Date:**_____

Clinic Name, Address & Phone: **OR** **Clinic Stamp:**

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Submit this form/documentation (.pdf scan or photo) or questions to: immunizations@healthcare.uiowa.edu

Written: 11/1819 Reviewed: 4/11/199 Revised: 7/21/20, 12/19/22, 8/1/24