Tuberculosis (PPD) Screening

*This form is **required** for **ALL** Culinary, Nursing & Respiratory students only*

Last Name: _____ First Name:_____ Middle:_____ DOB:_____

PART A: PAST DIAGNOSIS OF TUBERCULOSIS (TB)

1. Have you ever been sick with tuberculosis? Yes ___ No ___
2. Have you ever had a positive test for tuberculosis? Yes ___ No ___

The mantoux tuberculin skin test (PPD) or an interferon gamma release assay (IGRA) test are used for tuberculosis screening.

PART B: TUBERCULOSIS EXPOSURE RISK QUESTIONNAIRE

1. Were you born in or have you worked, lived, or traveled to any foreign countries for more than one month?
   Yes____ No ____
2. Have you had HIV infection or AIDS, diabetes, leukemia, lymphoma, or a chronic immune disorder?
   Yes ____ No ____If Yes, please specify _____
3. Do any of the following conditions or situations apply to you?
   a. Do you have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? Yes ____ No ____
   b. Have you ever lived with or been in close contact with someone known or suspected of being sick with TB? Yes_____No____
   c. Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital, or drug rehabilitation unit? Yes ____ No ____ Where: _____
4. Do you use or have you ever used:
   a. Medication for cancer or transplant rejections? Yes ___ No ___
   b. Oral steroid (prednisone 15mg/d for more than 1 month?) Yes ___ No ___
   c. Illicit intravenous drugs or crack cocaine? Yes ___ No ___

IMPORTANT NOTICE: **If you answered NO to all of the above, sign and submit this form to the requesting office**. If you answered YES to any question, a screening test for tuberculosis is required. Please submit the results of a tuberculosis screening done on you by your MD within the last 12 months.

Student Signature: _____ Date: _____

PART C: SCREENING TEST ATTENTION HEALTH CARE PROVIDER: If a student answers YES to any of the above, a screening test is required within one calendar year of admission. The screening test can be either a PPD or an IGRA. If the screening test is positive, a subsequent chest x-ray is mandatory.

PPD: Date Placed: _____ Date Read:_____ MM induration_____

IGRA: Date Obtained: _____ Specify Method: QFT-GIT, T-spot, Other _____IGRA Result: Negative___

Positive: _____ Intermediate_____ Borderline (T-spot Only)____ Date of Chest X-Ray_____ Result:_____

Health Care Provider Signature: _____ Date: _____

Health Care Provider Name (Print):_____ Date: _____

Health Care Provider Address: _____ Phone: _____

Please complete and return this form with your immunizations to one of the following:

- **Email –** healthservices@sunysullivan.edu
- **Fax** – (845) 434-3628
- **Mail to**:

  SUNY Sullivan – Health Services
  112 College Road
  Loch Sheldrake, NY 12759