VH Nursing
Virginia Highlands Community College

TB Screening Tool for Nursing Students

____________________________________	_____________
Last name, first name, middle initial	Date form completed
____________	(______)__________
Date of birth	_ Work phone number

Symptoms of active TB disease (circle all that are present)

Coughing (>3 weeks)	Chest pain	Fatigue
Night sweats	Coughing up blood	
Weight loss/poor appetite	Fever/chills	

Student's history (circle response)

			Comments
Have you ever had an adverse reaction to at TB skin test?	Yes	No	
Were you born outside of the US?	Yes	No	
Have you traveled or lived outside of the US in the past 2 years?	Yes	No	
Have you ever had a positive reaction to a TB skin test?	Yes	No	
Have you ever had a TB blood test? (Test by drawing blood in the lab)	Yes	No	
Have you ever had the BCG vaccine? (Vaccine given in Europe, etc for prevention of Tuberculosis)	Yes	No	
Have you ever been treated for latent TB infection?	Yes	No	
Have you ever been treated for active TB disease?	Yes	No	
Have you had household exposure to TB?	Yes	No	
Do you currently have or plans for immunosuppression, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication?	Yes	No	

Any symptoms of active TB or Yes to any of the above questions requires a chest x-ray and health care provider clearance documented on organization letterhead.

Student Signature_______________________________________ **Date**___________________________

Complete TB Education @ https://www.cdc.gov/tb/webcourses/TB101/default.htm. Download Certificate of Completion to CastleBranch.