Mount Saint Mary's University
LOS ANGELES

For Office Use Only

☐ **COMPLIANT**

_____

Last PPD CXR _____

Results _____

Tuberculosis Screening Form

To be completed by student. This document is a screening tool used to determine potential exposure to active Tuberculosis. You will be contacted by one of the Registered Nurses in MSMU Student Health Services if it is determined that clarification or testing is needed. All information is confidential.

Name (please print): _____ Student ID # _____
Last First M.I.

Country of Birth: _____ Year arrived in US (if born outside of US): _____

Date of Birth: _____ Cell Phone #: _____ Email: _____

Sections A and B are REQUIRED for ALL MSMU students

SECTION A: History of Tuberculosis (TB)? (please circle YES or NO)

1. Have you ever been sick with Tuberculosis (TB)? YES NO
2. Have you ever had a positive Tuberculosis Skin Test (PPD)? YES NO

   If yes, date of last Chest X-Ray or TB Quantiferon Test or T-SPOT _____
   Results shown must be within the past 2 years. Must provide a copy of the results.

SECTION B: At Risk for Tuberculosis (TB)? (please circle YES or NO)

1. Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, Caribbean, Russia, Latin America or Eastern Europe? YES NO

   If yes, what country? _____

   When? _____ How long? _____

   Reason: (please circle) Born there Tourist Work School Other _____

2. Have you had HIV infection, AIDS, diabetes, leukemia, lymphoma or a chronic immune disorder? YES NO

3. Do any of the following conditions or situations apply to you?

   a) Do you have a persistent cough? (3 weeks or more) with fever, night sweats, fatigue, loss of appetite or weight loss? YES NO

   b) Have you ever lived with or been in close contact to a person known or suspected of being sick with Tuberculosis? YES NO

   c) Have you ever lived, worked, or volunteered in any Homeless Shelter, Prison, Jail, Drug Rehabitation Unit, Nursing Home or Residential Healthcare Facility? YES NO

      If yes, where? _____

      When? _____ How long? _____

Student Signature: _____ Date: _____

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PLEASE MAKE A PERSONAL COPY OF ALL RECORDS BEFORE SENDING.

Chalon Student Health Services 12001 Chalon Road, Los Angeles, CA 90049-1526 or fax 310.954.4119
Doheny Student Health Services 10 Chester Place, Los Angeles, CA 90007-2598 or fax 213.477.2683

All forms can be downloaded from www.msmu.edu/healthforms

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