TB SCREENING

(INSTRUCTIONS: Double click the appropriate Yes or No box and click "checked")

1. Have you had recent contact with someone who has tuberculosis? ☐ Yes ☐ No
2. Has anyone living with you had tuberculosis? ☐ Yes ☐ No
3. Have you had a positive TB skin test? ☐ Yes ☐ No

If yes explain ______________________________

4. Have you had a chest x-ray that was abnormal? ☐ Yes ☐ No

   If yes, when ______________________________

5. Are you taking any medication that might affect your immune system? ☐ Yes ☐ No
6. Do you have any type of chronic disease? ☐ Yes ☐ No
7. Have you had any of the following symptoms?

Symptom		
Weight loss	☐ Yes	☐ No
Extremely tired or fatigued	☐ Yes	☐ No
Short of breath	☐ Yes	☐ No
Night sweats	☐ Yes	☐ No
Productive cough	☐ Yes	☐ No
Bringing up blood when you cough	☐ Yes	☐ No
Chest pain or pain around ribs	☐ Yes	☐ No
Unexplained fevers	☐ Yes	☐ No
Loss of appetite	☐ Yes	☐ No

If you answered yes to any of the above in question #7 please explain:______________________________

____

Signature:______________________________ Date:______________________________

CONSENT TO TUBERCULIN SKIN TEST

I,______________________________ acknowledge that I have no history of positive PPD Mantoux test and consent to have a tuberculin skin test.

I understand that in highly sensitive individuals, strong positive reactions including vesiculation, ulceration, or necrosis may occur at the test site.

I release Medical Staffing Solutions, LLC and its employees for all liability in connection with the administration and interpretation of this test.

Any known allergies? ☐ Yes ☐ No

If yes, list______________________________

Signature:______________________________ Date:______________________________

______________________________ ml in ☐ arm

Date Given

Administering Nurse Signature

______________________________ mm

Date Read

Nurse Reading Signature