FROSTBURG STATE UNIVERSITY

FOLLOW-UP FORM FOR POSITIVE TB RISK ASSESSMENT

Name:_____ Date of Birth:_____/_____/_____ Student ID #_____

A **IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ON THE TUBERCULOSIS RISK ASSESSMENT AND HAVE NEVER HAD A POSITIVE TUBERCULOSIS SKIN TEST (PPD), YOU MUST HAVE A PPD SKIN TEST (DONE IN THE USA) OR TB BLOOD TEST (IGRA) WITHIN 6 MONTHS PRIOR TO FIRST ATTENDANCE DATE AT FSU:**

Date of PPD:___/___/___ Date read:___/___/___ Result:____mm of induration Interpretation:☐Negative☐ Positive *(complete below)*

OR Date of Interferon Gamma Assay (IGRA) blood test: ____/____/____ Results: ☐ Negative ☐ Indeterminate ☐ Positive

(*Copy of lab report must be attached)*

Health Care Provider Name:_____ Telephone:_____

Authorized Signature:_____Date:_____

B **IF YOU HAVE A POSITIVE TUBERCULOSIS SKIN TEST OR BLOOD TEST (NOW OR BY HISTORY), THE FOLLOWING MUST BE COMPLETED BY A HEALTH CARE PROVIDER:**

Date of Positive PPD:_____/_____/_____ Result:_____mm of induration **OR**

Date of Interferon Gamma Release Assay (IGRA) blood test: _____/_____/_____ Result: ☐ Negative ☐ Indeterminate ☐ Positive

Chest X-ray: _____ Normal _____Abnormal Date:_____/_____/_____ (*Copy of the official X-ray/lab report must be attached*)

Treatment: _____No _____ Yes

Drugs, dose, frequency and dates:_____

_____

Health Care Provider Name:_____ Telephone:_____

Authorized Signature:_____Date:_____

C **ANYONE WITH A POSITIVE TUBERCULOSIS SKIN TEST OR BLOOD TEST, PLEASE ANSWER THE FOLLOWING QUESTIONS:**

1.	Have you had an unexplained cough for greater than three (3) weeks?	□Yes	□No
2.	Do you get night sweats?	□Yes	□No
3.	Have you had any unexplained weight loss?	□Yes	□No
4.	Have you had any unexplained fevers?	□Yes	□No
5.	Have you had any unexplained fatigue?	□Yes	□No
6.	Have you had an unexplained loss of appetite?	□Yes	□No
7.	Do you have a chronic medical condition such as diabetes, cancer or kidney disease?	□Yes	□No

Explain any "Yes" response here:_____

_____

Student Signature (Parent if student under age 18 years) _____ Date: _____

Mail or Fax to: Brady Health Center, Frostburg State University
101 Braddock Road Frostburg, MD 21532
Phone: 301-687-4310 Fax: 301-687-7050