Samford University
College of Health Sciences

Program of Study _____
SUID # _____

TUBERCULOSIS TESTING

_____ _____

LAST NAME **FIRST NAME** **MIDDLE** **BIRTH DATE**

All schools in the College of Health Sciences require tuberculosis (TB) screening prior to enrollment in courses, requirements vary by school and/or program. Please refer to your school/program's student handbook for specific requirements regarding tuberculosis (TB) screening requirements. Only this form will be accepted to meet program/school requirements. If you have received a BCG vaccine, an IGRA test is preferred. If you have a history of a positive TB skin test (≥10mm) or IGRA, please supply information regarding any evaluation and/or treatment below. Guidelines are based upon the recommendation of the CDC and the American College Health Association.

****Skin tests MUST be read 48-72 hours after they are placed.*
****The second test in a two-step TB test MUST be administered between one (1) and three (3) weeks after the first test was read.*

Section A	Test Type	Date Placed/Ordered	Date Read/Resulted	Results
No history of positive TB tests. Skin Test **OR** Blood Test Required	Skin Test #1	_____/_____/_____	_____/_____/_____	_____ mm
	Skin Test #2	_____/_____/_____	_____/_____/_____	_____ mm
	IGRA Blood Test □ T-spot □ Quantiferon Gold	_____/_____/_____	_____/_____/_____	_____ Negative _____ Positive
	Chest X-ray	_____/_____/_____	_____/_____/_____	_____ Negative _____ Positive

OR

Section B	Positive Test Type	Date Placed/Ordered	Date Read/Resulted	Results
History of Latent Tuberculosis, Positive Skin Test, or Positive Blood Test Chest X-Ray Required	Positive Skin Test	_____/_____/_____	_____/_____/_____	_____ mm
	Positive IGRA Blood Test □ T-spot □ Quantiferon Gold	_____/_____/_____	_____/_____/_____	
	Chest X-ray	_____/_____/_____	_____/_____/_____	_____ Negative _____ Positive
	Prophylactic medications for latent TB taken?		□ Yes □ No	
	Total duration of prophylaxis?		_____ months	
	Date of last annual TB symptom questionnaire (if applicable)		_____/_____/_____	□ Attach copy

OR

Section C		Date	Results
History of Active Tuberculosis History of Treatment Required	Date of Diagnosis	_____/_____/_____	□ Attach copy
	Date Treatment Completed	_____/_____/_____	□ Attach copy
	Date of last annual TB symptom questionnaire (if applicable)	_____/_____/_____	□ Attach copy
	Date of last Chest X-ray	_____/_____/_____	_____ Negative _____ Positive □ Attach copy

This form must be completed by one of the following licensed healthcare providers: MD, DO, NP/CRNP, PA, RN, or LPN. The form must be dated NO EARLIER THAN the last listed test date on the form to be valid. Nothing should be added to form after the healthcare provider signs and dates UNLESS the individual addition is signed, credentialed, and dated.

Licensed Healthcare Provider's Printed Name and Credentials: _____
Facility Name: _____
Facility Address: _____
City: _____ State: _____ Zip: _____
SIGNATURE OF PROVIDER: _____ DATE: _____