Tuberculosis Screening: To be completed by Student & Healthcare Provider

Last Name (print above)	First Name	Middle Name	Date of birth (mo. /day/ year)	Davidson ID#

Tuberculosis (TB) **Screening Questionnaire:** All new students are required to complete and submit the following TB screening questionnaire form. The form must be signed by a healthcare provider.

Section A: Tuberculosis (TB) Exposure Risk (to be completed by student)

1. Have you ever had close contact with persons known or suspected to have active TB disease? YES__ NO
2. Have you ever lived, worked or volunteered in any homeless shelter, prison/jail or long-term care facility? YES NO
3. Have you ever been a member of any of the following groups that may have an increased incidence of latent Tuberculosis infection or active TB disease: medically underserved, abuser of drugs or alcohol? YES NO
4. Were you born in, or have you lived, worked or visited for >1 month in one of the following countries? YES NO

If YES, where?___________________________ For how long?____________________ Dates visited/lived?________________________

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Côte d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominica
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Malta
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

If YES to any of the above questions, Davidson College requires TB testing within 6 months of arriving to campus. If the answer to all of the questions is NO, no further action is needed, and testing is not required.

Section B: For Healthcare Provider to complete if indicated by above questionaire: Tuberculosis (TB) Risk Assessment
Clinicians should review and verify the information above. Persons answering YES to any of the questions in the TB screening are required to have TB testing, unless a previous positive test has been documented. For previous positive tests, please send chest x-ray results, and if applicable, documentation of treatment. An IGRA (Interferon Gamma Release Assay) is required if testing is done outside the United States. Anyone with a positive TB test with no signs of active disease on chest x-ray should receive recommendation to be treated for Latent TB.

Tuberculin Blood Test: Date_____/______/______ Result: ________________ (required test if testing outside the US)
OR
Tuberculin Skin Test: Date administered: _____/_____/______ Date read: _____/______/______ Result _____________ mm

If TB test is Positive: Chest X-Ray is REQUIRED. Date done: ____/____/____ Result: Normal Abnormal (must attach radiology report)

Provider Name (Print) ____________________________________ **Address/Clinic Stamp**_________________________________

Provider Signature:____ **Date:** _____________________________________