Due: July 20th
Return form to:
St. Lawrence University
Student Health Services
76 Park Street
Canton, NY 13617
Or fax: 315-229-5514

St. Lawrence University Student Health Services
Tuberculosis (TB) Screening Record

Please read this form carefully and complete in full as per instructions.
This form is **required** for all new, incoming students.

Last Name: _____ First Name: _____ DOB: ___/___/_____

Step 1: Please answer all of the following questions***. If you answer YES to any question then Step 2 needs to be completed and signed by your health care provider.*** If all of the following questions are answered as "NO", sign and date the form and submit it with other required materials to St. Lawrence University Health Center.

Yes	No	
☐	☐	In the last 5 years, have you spent more than one month in any of the following regions: Africa, Asia, Latin America, or Eastern Europe?
☐	☐	Have you been exposed to someone with tuberculosis (TB) or someone who had tested positive for TB?
☐	☐	Have you ever had a PPD test be resulted as positive?
☐	☐	Do you have a weak immune system (HIV infection, immune suppressing medications, currently on chemotherapy)?
☐	☐	Have you worked or resided in an institutional setting (hospital, nursing home, homeless shelter, prison, etc.)?
☐	☐	Have you ever used a needle to inject illicit drugs?
☐	☐	Do you have diabetes, chronic kidney failure, leukemia/lymphoma, or an intestinal malabsorption syndrome (celiac sprue, Whipple's disease, cystic fibrosis, etc.)
☐	☐	Do you have any of the following symptoms?: Unexplained cough for 3 weeks, night sweats, unexplained fever (temperature > 38 °C or 100.4°F), unexplained weight loss, or severe unexplained fatigue

If you answered YES to any of the above questions, you MUST have your health care provider complete Step 2. If you answered No to all of the above, sign and date the bottom of the form where indicated.

Step 2: Students who answered yes to any of the above questions are ***REQUIRED*** to have a TB test ***BEFORE*** they arrive on campus. The test must be an interferon gamma release assay (IGRA) blood test (T-SPOT test, QuantiFERON-G, QuantiFERON-GIT, etc.)

IGRA Test Name: _____ Test Date: _____

IGRA Results Interpretation: _____
Please attach copy of IGRA report that includes Nil value, TB response, and mitogen response

If the IGRA result is ***positive or indeterminate***, a chest x-ray is required
Date of Chest X-ray __/__/____ Chest X-ray Results: _____
Please attach copy of X-ray report and notes describing any prophylactic treatment initiated

Provider Name: _____
Provider Signature: _____ Date: __/__/____
Address: _____ Phone Number: _____

By Signing below, the student is acknowledging that the questions above have been answered truthfully. If it is found that the student has not answered honestly, the student may be pulled from class until the requirements have been met and they will be liable for any charges accrued while completing the testing through St. Lawrence University's Health Center and hospital services.

Student Signature: _____ Date(mm/dd/yy): __/__/____
(Parent/Guardian if <18 years old)