

PROOF OF TUBERCULOSIS SCREENING, Page 1 of 2

Mail or fax to:

Jacksonville State University

Student Health Center

1701 Pelham Road South

Jacksonville, Alabama 36265-1602

P.256.782.5310 F.256.782.5307

NOTICE: The information provided on the Proof of Tuberculosis Screening is strictly confidential. Information may not be released to a third party unless you provide authorized release. This authorized release must comply with State and Federal Regulations. The information contained herein is required for medical treatment at the Student Health Center. Incomplete or inaccurate information may result in inability to register for classes, cancellation of class registration, or cause improper decision/diagnosis for your future medical care.

Name: Last	First	MI	JSU ID#:		
Address:		Gender:	SS#: - -		
City:	State:	Zip:	Birth date: / /		
Phone/Cell:			U.S. Citizen (Circle):	Y	N
Emergency Contact: Name:		Number:	Relationship:		

Tuberculosis Screening (Completed by Student)		
1. Have you ever been diagnosed with tuberculosis, had a positive Mantoux tuberculin skin test (TST), and/or positive blood test interferon gamma release assay (IGRA)? If "YES", STOP HERE and follow "Instruction I". If "NO", proceed to the next question.	Y	N
2. Have you worked with, lived with, or volunteered in a high risk setting (i.e. hospital, homeless shelter, prison, nursing home, HIV/AIDS clinic, and/or had any close contact with someone with active tuberculosis) for frequent or prolonged time intervals* within the last year? If "YES", STOP HERE and follow "Instruction II". If "NO", proceed to the next question.	Y	N
3. Do you currently have any of the following unexplained or undiagnosed symptoms: Fever, unexplained weight loss/loss of appetite, chest pain, night sweats, cough for greater than 3 weeks, coughing up blood? If "YES", contact your healthcare provider immediately. Follow "Instruction II". If "NO", proceed to the next question.	Y	N
4. Do you currently have one or more of the following medical conditions listed below? If "YES", STOP HERE and follow "Instruction II". If "NO" proceed to the next question.	Y	N
Diabetes Silicosis Chronic kidney failure Leukemia or lymphoma IV drug use Cancer of the head, neck, or lung Low body weight (10% or more below ideal)	Gastrectomy Jejunioleal (Intestinal) bypass Chronic malabsorption syndromes (i.e. Crohn's or ulcerative colitis) Prolonged corticosteroid therapy (e.g. Prednisone 15mg/daily or more for 1 month) Pulmonary fibrotic lesions on chest x-ray Abnormal immune system (e.g. HIV/AIDS, cancer chemotherapy, organ transplant recipient)	
5. Have you lived or traveled outside the United States for a period longer than 1 month in the past year? If "YES", STOP HERE and follow "Instruction II" OR have you been vaccinated with BCG (vaccination administered in countries outside of the United States)? If "YES", STOP HERE and follow "Instruction III". If "NO" proceed to signature and confirmation below.	Y	N

* The significance of potential risk should be discussed with a health care provider and evaluated.

If you answered "NO" to questions 1-5 on Proof of Tuberculosis Screening, Page 1 of 2, your tuberculosis proof of screening requirement is complete. By signing below, I certify the information given on this proof of tuberculosis screening is true and correct. I understand this screening is part of my official application to the University. I agree to notify the Student Health Center of any change that occurs in my physical or mental health either prior to my registration or while I am a student at the University.

Signature

Date

Printed Name

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Name: Last	First	MI	JSU ID#:
Birth date: / /			

The instructions below apply ONLY if you answered “Yes” to any question(s) on the Proof of Tuberculosis Screening, Page 1 of 2.

Instruction I: You are required to submit a report from a chest x-ray, completed in the United States, and performed within 6 months prior to entrance into the University. A copy of your treatment, including medications and dates of treatment, must be submitted to the Student Health Center at the address shown above. Based on your treatment and clinical findings, additional treatment may be required.

Chest x-ray completed / /	Evidence of treatment submitted to the Student Health Center	Y	N
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Instruction II: You are required to submit proof of tuberculosis (TB) test completed in the United States and performed within 12 months prior to entrance into the University. Acceptable TB tests include a Mantoux tuberculin skin test (TST) or a blood test interferon gamma release assay (IGRA). You must submit either the TST (including date placed, date read, results of induration in mm, and healthcare provider's signature) or a copy of the IGRA report. If either is positive, you are required to follow “Instruction I” above.

PPD Skin Test placed / /	PPD Skin Test read / /	mm induration		Provider Signature:		
Positive IGRA	Y	N	N/A	Positive TST and/or IGRA result; proceed to “Instruction I”	Y	N
A positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. Please sign below:						
Agrees to receive treatment:				Declines treatment at this time:		

Instruction III: You are required to submit proof of a blood test interferon gamma release assay (IGRA).

Positive IGRA	Y	N	N/A	Positive IGRA result; proceed to Instruction I	Y	N
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