

St. Joseph's Hospital and Health Center

30 West Seventh Street Dickinson, ND 58601-4399 Phone:(701) 456-4000

STUDENT/VOLUNTEER - TB SCREENING

Student/Volunteer Name: Dept: Date:

New Student/Volunteer: Yes No Phone:

Have you ever had a positive result to a tuberculin test? Any known exposure to TB? Yes No

DATE TEST GIVEN GIVEN BY?

Brand Lot# Exp. Date Site

DATE TEST READ: NEGATIVE POSITIVE READ BY:

(Within 48-72 Hours)

Parent/Guardian Signature approving TB Test (if under age 18):

Comments/Observations:

Positive TB Reactor in the past: please read the following information

Notify Employee Health if you have any of the following symptoms:

- ❖ Cough for more than two weeks
❖ Loss of appetite
❖ Tires easily
❖ Hemoptysis (blood tinged coughing)
❖ Night sweats
❖ Exposure to active TB
❖ Unexplained weight loss
❖ Fever/chills

Signature: Date:

PLEASE BRING THIS FORM WITH YOU TO YOUR TB TEST OR TO ORIENTATION

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If symptom free, please sign. Return the form to Employee Health, Mailbox #16.

Signature: Date: