

St. Joseph's Hospital and Health Center

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

STUDENT/VOLUNTEER - TB SCREENING

FIRST TIME Student/volunteer ONLY

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
❖ Hemoptysis (blood tinged coughing)
❖ Unexplained weight loss
❖ Loss of appetite
❖ Night sweats
❖ Fever/chills
❖ Tires easily
❖ Exposure to active TB

Signature: Date:

PLEASE BRING THIS FORM WITH YOU TO THE EMPLOYEE HEALTH OFFICE

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STUDENT/VOLUNTEER - TB SCREENING

RETURNING Student/Volunteer ONLY

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

Comments

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

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

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

Signature: Date: