SOUTHERN UNIVERSITY
AND AGRICULTURAL & MECHANICAL COLLEGE
School of Nursing

TB Screen Follow Up for Positive Skin Tests

Student _____ U#_____

Date of Reactive TB Skin Test_____

Preventative Therapy Initiated _____ Yes _____ No If Yes, Date Initiated_____

Name of Medication(s) _____

Currently Taking _____ Date Completed _____

Date of Last Check X-Ray _____ Results_____

Are You Currently Experiencing Any of the Following Symptoms?

	YES	NO	DATE OF ONSET
Productive Cough			
Afternoon Temperature Elevation			
Chills			
Night Sweats			
Chest Pains			
Blood-Tinged Sputum			
Loss of Appetite			
Unexplained Weight Loss			
Unexplained Persistent Rash			
Fatigue (Tiredness Without cause)			

Comments (Include Explanation of Any Symptoms for which YES was checked

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My signature indicates to the best of my knowledge, that I am free from any pulmonary (ling) symptoms, other than as indicated above. Should any of these symptoms occur between screenings, I understand that I am to notify the faculty health coordinator.

Student Signature_____ Date _____

NOTE: This form must be completed annually on all positive reactors to the TB skin test.