Ouachita Baptist University
Tuberculosis (TB) Screening/Testing

Name: _____ ID# _____

Tuberculosis screening is recommended for all entering students. If one of the criteria below apply, TB Screening is required such as a TB skin test or IGRA blood test (TB spot or QFT). BCG is not a substitute for TB screening, IGRA blood test is recommended if you have had a BCG.

If you have had a BCG, please give the date and location. BCG DATE: ___/___/___ Location: _____

Check any that apply?

- ☐ Were you born outside of the US in an endemic area such as **Asia, Africa, Central or South America or Eastern Europe**? Country of birth: _____
- ☐ Are you a U.S. Citizen who has lived outside of the United States for more than 8 weeks continuously or have visited above endemic areas frequently? Name of country(s):_____
- ☐ Have you had contact with a person known to have Tuberculosis?
- ☐ Do you have a medical condition that suppresses the immune system? List if you have any:_____

None of the above criteria applies and I choose not to do Tuberculosis screening.
Name: _____ Date: _____

If **ANY** of the above criteria applies to you, the following **MUST** be filled out and signed by a health care provider.

TB skin test within last 6 months prior to entering Ouachita:

Date given ___/___/___ Date Read ___/___/___ Induration _____mm Results: Pos. / Neg.
OR
TB blood IGRA Date given ___/___/___ Type: T-Spot/QuantiFERON-TB Gold Results: Pos. / Neg.

Have been treated for TB: Date completed treatment __/___/___ Medications received: _____
If either TB skin or blood tests results are positive, a chest x-ray is required.
Chest x-ray date ___/___/___ Results: _____
If positive, must submit date of treatment or treatment plan by health care provider or Public Health Care facility.

Print Name of Health Care Provider_____

Health Care Provider Signature: _____Date: ___/___/___