University of Mary Washington
1301 College Avenue, Fredericksburg VA 22401
Student Health Center – Lee Hall 112
Phone 540-654-1040, FAX 540-654-1077
https://students.umw.edu/healthcenter/

UMW TB Screening Form

All Forms are to be Submitted Electronically through the Student Portal at:
https://students.umw.edu/healthcenter/

Student Name: **Date:**

Tuberculosis Screening

Based on the guidelines published by the *American College Health Association*, the recommendations from the *Centers for Disease Control* (CDC) and the *American Thoracic Society*, tuberculosis screening is required within six months of college entry primarily by conducting a **Risk Assessment.** For more information, visit www.acha.org or refer to the CDC's *Core Curriculum on Tuberculosis* available at state health departments or at the following website: www.cdc.gov/tb/.

If answered yes to any of the following question, a TB test is required for entrance into college.

Question 1 **Has the student ever had a positive TB test?** ☐ **Yes** ☐ **No**

If NO ....proceed to Question 2.
If YES ....please submit the chest x-ray report.

Question 2 **Does the student have SIGNS or SYMPTOMS** of **ACTIVE TB DISEASE**? ☐ **Yes** ☐ **No**

(Fever, night sweats, chills, fatigue, unintended weight loss, poor appetite, coughing up blood, cough lasting 3 weeks or longer)

If NO ....proceed to Question 3.
If YES ....a Tuberculin skin test (TST) or Interferon Gamma Release Assay Test (IGRA) test with result is required.

Question 3 **Is the student a member of a HIGH-RISK GROUP or at risk for TB progression?** ☐ **Yes** ☐ **No**

Students are in a high risk group if they were exposed to TB, inject illegal drugs … or they have resided in, or worked in high risk congregate settings such as long-term care facilities, homeless shelters, or correctional facilities … or they have HIV, **diabetes** , cancer, chronic renal failure, silicosis, leukemias, lymphomas, low body weight (10% below ideal), gastrectomy, jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone >= 15 mg/day for >= one month), other immunosuppressive therapy, solid organ transplant, chest x-ray with evidence of prior healed TB or other immunosuppressive disorders.

If NO ....proceed to Question 4.
If YES ....a TST or IGRA test with result is required.

Question 4 **Has the student LIVED/TRAVELED > 3 months where TB is endemic (including birth)?** ☐ **Yes** ☐ **No**

Any Country **OTHER** than those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

If NO to #1, #2, #3 and #4 neither a TB test nor a chest-ray is required. Please sign below.
If YES ....a TST or IGRA test with result is required.

Tuberculosis Testing - please document testing and attach copy of lab and/or x-ray report.

A. **Tuberculin Skin Test** Date given:____________________ Date read:__________________

Result:____________mm (record actual millimeters of induration, not redness. If no induration write "0")

Interpretation (based on mm of induration as well as risk factors) ☐ **Positive** ☐ **Negative**

B. **Interferon-Gamma Release Assay** Date:_______________ **T-spot** ☐ **Positive** ☐ **Negative** or **QFT-G** ☐ **Positive** ☐ **Negative**

(IGRA preferred if non-US born or received BCG vaccine**)**

C. **Chest X-ray** (required if TB test (either TST or IGRA is positive))

Results: ☐ **Normal** ☐ **Abnormal** **Date of Chest x-ray**: ______________

☐ **Treatment:**_______________ **Date:**______________x______months

Your health care provider must sign here to verify tuberculosis screening.

____ ________________ (________)______________
Signature of Health Care Provider **Date** **Phone Number**