TB Symptom Checklist

For Students with POSITIVE TB Results Only

Part 1: To be completed by the student

Last Name: ______________________________ First Name: ______________________________

ID Number: ______________________________ USF E-mail: ______________________________

Program: ☐ BSN ☐ MSN ☐ MPH ☐ MSBH ☐ DNP ☐ PsyD ☐ Non-Degree Seeking ☐ EMT

Part 2: To be completed by the healthcare provider

Please check if the above name has had any of the following:	***Yes***	***No***
1. Previous TB skin test	☐	☐
2. Previous POSITIVE TB skin test	☐	☐
3. BCG Vaccine	☐	☐
4. Active TB	☐	☐
5. INH (isoniazid) medication *Date Received:* ________/_________/________	☐	☐

Has the above named experienced any of the following symptoms:	***Yes***	***No***
1. New, productive cough for more than 2 weeks	☐	☐
2. Coughing up blood	☐	☐
3. Hoarseness lasting more than 3 weeks	☐	☐
4. Night sweats lasting more than a week	☐	☐
5. Fever and/or chills lasting more than 1 week	☐	☐
6. Unintentional weight loss over the past 2 months	☐	☐
7. Unusually/excessively tired over the past 3 weeks	☐	☐

Healthcare Provider's Signature

Name: ______________________________ Certification: MD / NP / PA / RN

I certify that the above mentioned student does NOT show signs of active Tuberculosis.

HCP Signature: ______________________________ ***(Office Stamp)***

Date: ________/_________/________

Once you have completed your TB Symptom Checklist, you must upload a copy into AdvisorTrac along with copies of all supporting documentation (ex: lab results).