DARTMOUTH COLLEGE HEALTH SERVICE
*5-7 Rope Ferry Road, Hanover, NH 03755*
*Phone: (603) 646-9405 - Fax: (877) 884-8110*

# TUBERCULOSIS SCREENING FORM

**Student Name:**_____ **Date of Birth:***(MM/DD/YY)*_____

## *SECTION A- COMPLETED BY STUDENT*

1. Were you born in any of the countries listed on **page 2**? ____**YES** ____ **NO**
2. Have you lived or traveled for more than 1 month in any countries on **page 2?** ____**YES** ____ **NO**
3. Have you worked, volunteered, or lived in potentially high risk setting such as prison, a longterm care facility, a homeless shelter, residential facility, drug treatment center, or lived with person with HIV/AIDS? ____**YES** ____ **NO**
4. Have you had a recent or prolonged contact with someone with infectious or active Tuberculosis? ____**YES** ____ **NO**
5. Do you have history of a positive TB test? (**IF YES, PROCEED DIRECTLY TO SECTION C)** ____**YES** ____ **NO**

IF YOU ANSWERED "YES" to any of these questions you are required to submit a **Mantoux 5TU PPD** skin test **OR** an **Interferon Gamma Release Assay (IGRA)**. These test must be administered within **6 months** prior to entrance to Dartmouth College. Have your health care provider complete and sign **Section B**.

IF YOU ANSWERED "NO" to all questions, **NO FURTHER ACTION IS REQUIRED.** Please sign, date and submit this form to the Medical Records Office.

STUDENT SIGNATURE:_____ DATE:_____

*(BY SIGNING, I ATTEST THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE)*

## *SECTION B- TO BE COMPLETED BY HEALTH CARE PROVIDER (IF POSITIVE RESULT, PROCEED TO SECTION C)*

- *TB TESTING IS REQUIRED EVEN IF YOU HAVE HAD THE BCG VACCINE*
- *A TEST > 10mm IS CONSIDERED POSITIVE TB FROM HIGH PREVALENCE COUNTRIES, > 5mm IF YOU ARE IMMUNOCOMPROMISED*

**PPD TEST:** Date Planted: _____ Date Read:_____ Induration:____ mm. NEG:____ POS:____ **READ WITHIN 48-72 HOURS**

**IGRA RESULTS**: *(LAB REPORT MUST BE ATTACHED):* Positive:_____ Negative:_____ Type:_____ Date:_____

Signature of Provider MD/PA/APRN/RN:_____ Printed Name:_____ Date:_____

## *SECTION C- TO BE COMPLETED BY PROVIDER IF A POSITIVE TB TEST OR HISTORY OF TB*

- If **POSITIVE** TST, T-SPOT or IGRA - ***CHEST X-RAY NEEDS TO BE ADMINISTERED***
- Attach a copy of the chest x-ray report, the chest x-ray must be dated within 6 MONTHS of entrance to Dartmouth, it must also be written or officially translated into English.
- Did the student receive TB therapy? .....**NO** .....**YES** - If yes, please provide the following:

  **START DATE**..... **COMPLETION DATE**..... **TYPE(MEDICATION)**.....
- Provide a clinical evaluation. Does the patient exhibit cough, hemoptysis, fever, chills, night sweats or weight loss?

  **NO**.....**YES**..... If yes, please describe .....

Signature of Provider MD/PA/APRN/RN:_____ Printed Name:_____ Date:_____

If you were born in any of the **countries listed below or traveled/lived in any of these countries for more than one month**, you are REQUIRED to submit a Mantoux PPD skin test or a copy of an Interferon gamma release assay (IGRA). The test must have been performed within six months prior to your Dartmouth registration date.

*Source: World Health Organization Global Tuberculosis Report 2021*

https://www.who.int/news/item/17-06-2021-who-releases-new-global-lists-of-high-burden-countries-for-tb-hiv-associated-tb-and-drug-resistant-tb

ANGOLA
AZERBAIJAN
BANGLADESH
BELARUS
BOTSWANA
BRAZIL
CAMEROON
CENTRAL AFRICAN REPUBLIC
CHAD
CHINA
CONGO
DEMOCRATIC PEOPLE'S
REPUBLIC OF KOREA
DEMOCRATIC REPUBLIC OF THE
CONGO
ETHIOPIA
GHANA
GUINEA-BISSAU
INDIA
INDONESIA
KAZAKHSTAN
KENYA
KYRGYZSTAN
LESOTHO
LIBERIA
MALAWI
MOZAMBIQUE
MYANMAR
NAMIBIA
NIGERIA
PAKISTAN
PAPUA NEW GUINEA
PERU
PHILIPPINES
REPUBLIC OF MOLDOVA
RUSSIAN FEDERATION
SOMALIA
SOUTH AFRICA
SWAZILAND
TAJIKISTAN
THAILAND
UGANDA
UKRAINE
UNITED REPUBLIC OF TANZANIA
UZBEKISTAN
VIETNAM
ZAMBIA
ZIMBABWE