Wellness Center

TB Questionnaire

FAILURE IN RETURNING THIS FORM WILL RESULT IN A HOLD ON THE STUDENT'S ACCOUNT AND PREVENT THE STUDENT FROM REGISTERING FOR CLASSES.

Please complete and return this form before registration to the Wellness Center welnesscenter@udmercy.edu or mail to the Wellness Center, University of Detroit Mercy, 4001 W. McNichols Rd., Detroit, MI 48221-3038. If you have any questions, please call the Wellness Center at 313-993-1185.

Name: _____ T#:_____ Date:_____

Phone Number:_____ Email:_____

Please answer all TB questions. Please refer to the list of countries that have high rates of TB. **If you answer "Yes" to one or more of the questions**, you must submit this form and documentation of a recent (within the past year) TB test (see below).

1) Have you ever had a positive TB skin test? ( )Yes ( )No
2) Have you had close contact with anyone who was sick with Tuberculosis? ( )Yes ( )No
3) Were you born in or have you immigrated from one of the countries listed below? ( )Yes ( )No
4) Have you traveled to or lived for more than one month in any of the countries listed below? ( )Yes ( )No
5) Do you have any known immunodeficiencies? ( )Yes ( )No

Please check one of the following:

( ) I am required by the guidelines above to be tested for TB. I have enclosed my TB skin test results.
( ) I have had a positive TB skin test and I am including documentation of my chest x-ray.
( ) I am not required to take a TB skin test according to the above guidelines.

Student Signature: _____ Date:_____

Parent Signature (if student is under 18) _____ Date:_____

Afghanistan	Central African Republic	Ghana	Malawi	Pakistan	South Africa
Algeria	Chad	Guam	Malaysia	Palau	Sri Lanka
Angola	China	Guatemala	Maldives	Papa New Guinea	Sudan
Argentina	China, Hong Kong SAR	Guinea	Mali	Paraguay	Suriname
Armenia	China, Macao SAR	Guinea-Bissau	Marshall Islands	Peru	Swaziland
Azerbaijan	Colombia	Guyana	Mauritania	Philippines	Tajikistan
Bangladesh	Comoros	Haiti	Mauritius	Poland	Thailand
Belarus	Congo	Honduras	Mexico	Portugal	Togo
Belize	Cote d'Ivoire	India	Micronesia	Qatar	Turkmenistan
Benin	Djibouti	Indonesia	Mongolia	Republic of Korea	Tuvalu
Bhutan	Dominican Republic	Iraq	Morocco	Republic of Moldova	Uganda
Bolivia	DPR Korea	Kazakhstan	Mozambique	Romania	Ukraine
Bosnia & Herzegovina	DR Congo	Kenya	Myanmar	Russian Federation	UR Tanzania
Botswana	Ecuador	Kiribati	Namibia	Rwanda	Uzbekistan
Brazil	El Salvador	Kyrgyzstan	Nauru	Sao Tome and Principe	Vanuatu
Brunei Darussalam	Equatorial Guinea	Lao PDR	Nepal	Saudi Arabia	Vietnam
Burkina Faso	Eritrea	Latvia	Nicaragua	Senegal	Walls & Futuna
Burundi	Ethiopia	Lesotho	Niger	Seychelles	Yemen
Cambodia	Gabon	Liberia	Nigeria	Sierra Leone	Zambia
Cameroon	Gambia	Lithuania	Niue	Solomon Islands	Zimbabwe
Cape Verde	Georgia	Madagascar	Northern Mariana Islands	Somalia	

If you answered YES to ANY of the above questions, you are required to have your health care provider administer a TB test and complete this section. Return the form and your test documentation to the address above.

PPD test date:_____ Results:_____mm induration ( )Negative ( )Positive—**PLEASE SEE BELOW**

Provider's printed name:_____ Signature:_____ Ph#_____

If the **PPD** test is **POSITIVE**, please have your health care provider complete the information below:

Chest x-ray test date: _____ Results: ( )Negative ( )Positive ( )Other:_____

Were you counseled on TB medication? ( )Yes ( )No

Did you decline TB medication? ( )Yes ( )No

Did you take or are you presently taking TB medication? ( )Yes ( )No

If Yes, please indicate: START DATE:_____(mm/dd/yyyy) STOP DATE:_____(mm/dd/yyyy)

Provider's printed name:_____ Signature:_____ Date:_____

Detroit, Michigan 48221-3038
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