

APPENDIX E



NURSING DIVISION
ANNUAL TB SCREENING

Name _____ SSN _____ Date _____

Have you ever been treated for TB exposure? YES
 NO

If yes, did you complete the medication regime? YES
 NO

Do you have a persistent cough? YES
 NO

Do you have night sweats? YES
 NO

Have you had an unexplained weight loss? YES
 NO

Do you have unusual fatigue? YES
 NO

RECOMMENDATIONS: _____

Student Signature

Faculty Signature