BOISE STATE UNIVERSITY
COLLEGE OF HEALTH SCIENCES
School of Nursing

Annual Tuberculosis Symptom Screen

Name: _____ Date: _____

Program: _____ Student ☐ Faculty ☐

Our records show you have indicated a known latent TB infection *or* had a positive baseline TB screening test. Per CDC guidelines and our contractual agreements with healthcare partners an annual symptom screening will be required.

For more information, please refer to the following resources and speak to your healthcare practitioner:
Questions and Answers About Tuberculosis
About Active Tuberculosis
About Inactive Tuberculosis

Guidelines for Healthcare Workers

- Clinical Testing Guidance for Tuberculosis: Health Care Personnel
- Frequency of Tuberculosis Screening and Testing for Health Care Personnel
- Baseline Tuberculosis Screening and Testing for Health Care Personnel

Please complete the following symptom screening marking 'yes' or 'no' to accurately represent whether or not you are experiencing each of these signs and symptoms currently.

Symptoms	Yes	No
1. New cough lasting more than three (3) weeks, unexplained by a pre-existing diagnosis	◯	◯
2. Persistent weight loss without dieting	◯	◯
3. Persistent fever	◯	◯
4. Night sweats	◯	◯
5. Loss of appetite	◯	◯
6. Weakness or fatigue	◯	◯
7. Coughing up blood or sputum (phlegm from deep inside the lungs)	◯	◯
8. Chills	◯	◯
9. Chest pain	◯	◯

Student's Signature: _____ Date: _____