



# Tuberculosis Screening Form

Please answer and send or bring into the University Health Partners for registration.

MSU- Bozeman PO Box 173260  
 Bozeman, MT 59717-3260  
[www.montana.edu/health](http://www.montana.edu/health)

Telephone: (406) 994-2311  
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 E-mail: [immune@montana.edu](mailto:immune@montana.edu)

Student's Name:	Date of Birth:	Student ID #:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Address:	Phone number:	Today's Date:
<input type="text"/>	<input type="text"/>	<input type="text"/>

## Past History:

- |  | YES   | NO    |
|--|-------|-------|
| 1. Have you lived in any of the following countries for six months or more?<br>Afganistan, Bangladesh, Bolivia, Brazil, Cambodia, China, Congo, Ethiopia,<br>Ghana, India, Indonesia, Kazakhstan, Kenya, Mongolia, Mozambique,<br>Myanmar, Namibia, Nepal, Nigeria, Pakistan, Peru, Philippines, Republic<br>of Korea, Russian Federation, South Africa, Tajikistan, Thailand, Uganda,<br>United Republic of Tanzania, Viet Nam, Zambia, Zimbabwe.<br><small>(Sources: WHO Report 2014: Global Tuberculosis Controle, P. 9, Table 2.1 listing "High<br/>           TB burden countries, and MSU statistics.)</small> | _____ | _____ |
| 2. Have you used interavenous drugs or had a history of alcoholism?  | _____ | _____ |
| 3. Do you have cancer, Leukemia, Kidney disease, diabetes, AIDS/HIV or take immunosuppressive medications such as prednisone?  | _____ | _____ |
| 4. Have you been in close contact with someone with tuberculosis?  | _____ | _____ |
| 5. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home or other long term treatment facility?  | _____ | _____ |

**IMPORTANT:** If you answered Yes to any of these questions, you are required to have a PPD skin test before you register for classes at MSU-Bozeman. This PPD must be done within 12 months prior to beginning your classes. You can obtain the PPD skin test from your local health provider, or you can come to the MSU UHP Medical Services to receive the test.

## TB SKIN TEST

Did you receive BCG? (Vaccination for Tuberculosis often given in foreign countries) YES \_\_\_\_\_ NO \_\_\_\_\_

Date PPD Applied:	<input type="text"/>	Medical Professional's Office Stamp:
Date PPD Read:	<input type="text"/>	
Size of Induration:	<input type="text"/> mm	
Medical Professional's Official Name:	<input type="text"/>	Medical Professional's Official Signature:
<input type="text"/>	<input type="text"/>	<input type="text"/>