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 wellnesscenter@udmercy.edu or mail to the University of Detroit Mercy, Wellness Center, 4001 W McNichols Rd., 104 West Quad, 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 and QuantiFERON-TB Gold test (blood draw).
( ) 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	Cabo Verde	Ecuador	Iraq	Mauritius	Panama	South Sudan	Vanuatu
Algeria	Cambodia	El Salvador	Kazakhstan	Mexico	Papua New Guinea	Sri Lanka	Venezuela (Bolivarian Rep. of)
Angola	Cameroon	Equatorial Guinea	Kenya	Micronesia (Fed. States of)	Paraguay	Sudan	
Anguilla	Central African Republic	Eritrea	Kiribati	Mongolia	Peru	Suriname	Viet Nam
Argentina	Chad	Ethiopia	Kuwait	Montenegro	Philippines	Swaziland	Yemen
Armenia	China	Fiji	Kyrgyzstan	Morocco	Portugal	Syrian Arab Republic	Zambia
Azerbaijan	China, Hong Kong SAR	Gabon	Lao People's Dem. Republic	Mozambique	Qatar	Tajikistan	Zimbabwe
Bangladesh	China, Macao SAR	Gambia	Latvia	Myanmar	Republic of Korea	Tanzania (United Republic of)	
Belarus	Colombia	Georgia	Lesotho	Namibia	Republic of Moldova	Thailand	
Belize	Comoros	Ghana	Liberia	Nauru	Romania	Timor-Leste	
Benin	Congo	Greenland	Libya	Nepal	Russian Federation	Togo	
Bhutan	Cote d"Ivoire	Guam	Lithuania	New Caledonia	Rwanda	Tunisia	
Bolivia	Democratic People's Republic of Korea	Guatemala	Madagascar	Nicaragua	Sao Tome & Principe	Turkmenistan	
Bosnia & Herzegovina	Democratic Republic of the Congo	Guinea	Malawi	Niger	Senegal	Tuvalu	
Botswana	Djibouti	Guinea-Bissau	Malaysia	Nigeria	Serbia	Uganda	
Brazil	Dominican Republic	Guyana	Maldives	Northern Mariana Islands	Sierra Leone	Ukraine	
Brunei Darussalam		Haiti	Mali	Pakistan	Singapore	Uruguay	
Bulgaria		Honduras	Marshall Islands	Palau	Solomon Islands	Uzbekistan	
Burkina Faso		India	Mauritania		Somalia		
Burundi		Indonesia			South Africa		

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 this 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: _____Phone:_____

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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