Wellness Center

TB Questionnaire

UNIVERSITY OF DETROIT MERCY
Build A Boundless Future

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 T spot (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	Burkina Faso	Eritrea	Iraq	Mexico	Palau	South Korea (Rep of Korea)	Vanuatu
Albania	Burundi	Eswatini (formerly Swaziland)	Kazakhstan	Micronesia (Fed States of)	Panama	South Sudan	Venezuela
Algeria	Cabo Verde	Ethiopia	Kenya	Moldova (Rep of)	Papua New Guinea	Sri Lanka	Viet Nam
Angola	Cambodia	Fiji	Kiribati	Mongolia	Paraguay	Sudan	Yemen
Anguilla	Cameroon	French Polynesia	Kuwait	Morocco	Peru	Suriname	Zambia
Argentina	Central African Republic	Gabon	Kyrgyzstan	Mozambique	Philippines	Tanzania (United Rep)	Zimbabwe
Armenia	Chad	Gambia	Lao People's Dem Republic	Myanmar (Burma)	Portugal	Tajikistan	
Azerbaijan	China	Georgia	Latvia	Namibia	Qatar	Thailand	
Bahamas	China, Hong Kong SAR	Ghana	Lesotho	Nauru	Romania	Timor-Leste	
Bangladesh	China, Macao SAR	Greenland	Liberia	Nepal	Russian Federation	Tokelau	
Belarus	Colombia	Guam	Libya	Nicaragua	Rwanda	Togo	
Belize	Comoros	Guatemala	Lithuania	Niger	Sao Tome and Principe	Tunisia	
Benin	Congo	Guinea	Madagascar	Nigeria	Senegal	Turkmenistan	
Bhutan	Cote d'Ivoire	Guinea-Bissau	Malawi	Niue	Serbia	Tuvalu	
Bolivia	Dem Rep of the Congo	Guyana	Malaysia	Northern Mariana Islands	Sierra Leone	Uganda	
Bosnia & Herzegovina	Djibouti	Haiti	Maldives	North Korea (Dem People's Republic)	Singapore	Ukraine	
Botswana	Dominican Republic	Honduras	Mali	Pakistan	Solomon Islands	Uruguay	
Brazil	Ecuador	India	Marshall Islands		Somalia	Uzbekistan	
Brunei Darussalam	El Salvador	Indonesia	Mauritania		South Africa		
Bulgaria	Equatorial Guinea						

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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