University of Miami Nursing/Medical/Physical Therapy
Annual Tuberculosis Screening and Testing Form

Name _____ UM Student # _____
Last, First M. I.

TUBERCULOSIS SCREENING

Annual PPD Screening

PPD (Mantoux 5TU only) ☐ Positive ☐ Negative _____ mm induration _____ _____ _____
month date year

Chest X-ray (required for positive PPD)

Chest X-ray ☐ Normal ☐ Abnormal _____ _____ _____
month date year

(copy of chest x-ray must be attached to this form)

If PPD was positive and chest X-ray was negative: Was treatment of latent Tb offered? ☐ Yes ☐ No

Was treatment of latent Tb accepted? ☐ Yes ☐ No

Details of treatment including drug, dose, frequency and duration:

_____

_____ _____ _____
Name & title of physician or health care provider Signature Date

Symptom Review:

Do you have any of the following?

Cough (duration of 3 wks or more)	yes _____ no _____	Night Sweats	yes _____ no _____
Chest Pain	yes _____ no _____	Appetite loss	yes _____ no _____
Hemoptysis (coughing up blood)	yes _____ no _____	Weight loss	yes _____ no _____
Fever	yes _____ no _____	Fatigue	yes _____ no _____
Chills	yes _____ no _____		

_____ _____
Signature of Student Date

_____ _____ _____
Name & title of physician or health care provider Signature Date

_____
Address

_____
City State Zip Telephone

ENTER INFORMATION at **mystudenthealth.miami.edu** Scan & save form on your computer or take a picture with your mobile device, and upload it at **mystudenthealth.miami.edu** Alternatively, enter information and scan and email, fax or mail to: studenthealth@miami.edu, Fax (305) 284-4098, 5513 Merrick Drive, Coral Gables, FL 33146

Immunization information is provided to the State of Florida FLORIDA SHOTS immunization registry. Students can opt out of this immunization registry by completing an opt-out form, available at www.miami.edu/student-health

VERIFICATION OF RECEIPT AND PROCESSING CAN BE OBTAINED at www.mystudenthealth.miami.edu **3.25.15**