



**NON-HEALTHCARE & NON-CLINICAL
HEALTHCARE PROGRAMS**

Complete sections A and B. If you answer yes to any questions, please have your health care provider complete section C.

Last Name :

First Name :

Harvard ID# :

Country of Birth :

Year Arrived in US :

SECTION A: History of Tuberculosis(TB)?

- | | | |
|--|-----|----|
| 1. Have you ever been sick with tuberculosis? | YES | NO |
| 2. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT? | YES | NO |

SECTION B: At Risk for Tuberculosis (TB)?

- | | | |
|---|-----|----|
| 1. Are you currently in a health-related academic program/major? | YES | NO |
| 2. Were you born in, or have you lived, worked, or visited for more than one month in any of the following:
Asia, Africa, South America, Central America, or Eastern Europe? | YES | NO |
| a. If yes, what country? _____ How long? _____ | | |
| b. Reason? Born There Tourist Work School Other | | |
| 1. Have you had HIV infection, AIDS, diabetes, leukemia, lymphoma, or a chronic immune disorder? | YES | NO |
| 2. Do any of the following conditions or situations apply to you? | | |
| a. Persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? | YES | NO |
| b. Lived with or been in close contact with a person known or suspected of being sick with TB? | YES | NO |
| c. Lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit,
nursing home, or residential healthcare facility? | YES | NO |

Student Signature

Date

If you answered no to all of the above questions, skip Section C; you are done. If you answered yes to any of the above questions, your healthcare provider must complete Section C below.

SECTION C: ATTENTION HEALTH CARE PROVIDER: If the patient answered YES to any of the above questions, proof of a PPD, QuantiFERON –TB Gold, or T-SPOT is REQUIRED. If PPD results are 10mm or more, or QuantiFERON-TB Gold or T-SPOT are positive, a chest x-ray is REQUIRED. Testing and/or chest x-rays must be done within one calendar year prior to admittance (unless history of positive PPD). If the student has a history of positive PPD, a chest x-ray is required. History of BCG vaccination does not prevent testing of a member of a high-risk group.

PPD: Date placed _____ Date read _____ # of mm induration _____

QuantiFERON-TB Gold or T-SPOT: Result date _____ Result (attach lab report) _____

Date of chest x-ray _____ Result _____

If negative CXR and positive PPD, did the student complete a course of INH? YES NO
• If yes, when (months & year) _____ and for how many months did the student take INH? (# of months) _____

PROVIDER INFORMATION REQUIRED

**PHYSICAL SIGNATURE & STAMP OF HEALTHCARE
PROVIDER REQUIRED**

Phone number of practice

Date