Salem State University

Health Form

Tuberculosis Risk Questionnaire

Name of Student

Date of Birth (MM/DD/YYYY)

SSU Student ID #

PART 1: TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (TO BE COMPLETED BY INCOMING STUDENTS)

Have you ever had close contact with persons known or suspected to have active TB Disease? ☐ Yes ☐ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? ☐ Yes ☐ No
(If yes, please circle the country below)

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS				
Afghanistan	Comoros	India	Namibia	South Africa
Algeria	Congo	Indonesia	Nauru	South Sudan
Angola	Cote d'Ivoire	Iraq	Nepal	Sri Lanka
Anguilla	(DPR of) Korea	Kazakhstan	Nicaragua	Sudan
Argentina	(DR of) Congo	Kenya	Niger	Suriname
Armenia	Djibouti	Kiribati	Nigeria	Tajikistan
Azerbaijan	Dominica	Kuwait	Niue	Tanzania (United Republic of)
Bangladesh	Dominican Republic	Kyrgyzstan	Northern Mariana Islands	Thailand
Belarus	Ecuador	Lao (PDR)	Pakistan	Timor-Leste
Belize	El Salvador	Latvia	Palau	Togo
Benin	Equatorial Guinea	Lesotho	Panama	Tokelau
Bhutan	Entrea	Liberia	Papua New Guinea	Tunisia
Bolivia (Plurinational State of)	Eswatini	Libya	Paraguay	Turkmenistan
Bosnia and Herzegovina	Ethiopia	Lithuania	Peru	Tuvalu
Botswana	Fiji	Madagascar	Philippines	Uganda
Brazil	French Polynesia	Malawi	Portugal	Ukraine
Brunei Darussalam	Gabon	Malaysia	Qatar	Uruguay
Bulgaria	Gambia	Maldives	Republic of Kora	Uzbekistan
Burkina Faso	Georgia	Mali	Republic of Moldova	Vanuatu
Burundi	Ghana	Malta	Romania	Venezuela (Bolivarian Republic of)
Cabo Verde	Greenland	Marshall Islands	Russian Federation	Viet Nam
Cambodia	Guam	Mauritania	Rwanda	Yemen
Cameroon	Guatemala	Mexico	Sao Tome and Principe	Zambia
Central African Republic	Guinea	Micronesia (FS of)	Senegal	Zimbabwe
Chad	Guinea-Bissau	Mongolia	Sierra Leone	
China	Guyana	Morocco	Singapore	
China - Hong Kong	Haiti	Mozambique	Solomon Islands	
Colombia	Honduras	Myanmar	Somalia	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2020.
Countries with incidence rates of > 20 cases per 100,000 population. For future updates, refer to **www.who.int/tb/country/en/.**

In the past five years have you:

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB Disease? (If yes, check the countries above) ☐ Yes ☐ No

Have you been a resident and/or employee of high-risk congregate settings? (e.g., correctional facilities, long-term care facilities, and homeless shelters) ☐ Yes ☐ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease? ☐ Yes ☐ No

Medically under served, low-income, or abusing drugs or alcohol

If the answer is YES to any of the above questions, Salem State University requires documentation of further evaluation.
If the answer to all of the above questions is NO, no further testing or further action is required.
*The significance of the travel exposure should be discussed with a health care provider and evaluated.

Tuberculosis Risk Questionnaire (continued)

TUBERCULIN (TB) HISTORY AND REQUIREMENTS

Students from countries in which TB is prevalent must have a T-Spot® (blood test) at Salem State University's Health Services department within four weeks of the first day of classes, if testing has not been done.

Check all Tuberculin screening tests you have had:

☐ PPD, Mantoux (skin tests) Date planted: _____ Date read: _____
Result: _____ mm of induration

☐ T-SPOT ® (blood test) Date: _____ Result: ☐ Positive ☐ Negative

☐ QuantiFERON®-TB Gold (blood test) Date: _____ Result: ☐ Positive ☐ Negative

☐ Chest X-Ray Date: _____ Result: ☐ Positive ☐ Negative

☐ History of treatment for Tuberculosis disease

Start Date: _____ Duration: _____

Type of Treatment: _____

☐ History of treatment for positive PPD without disease

Start Date: _____ Duration: _____

Type of Treatment: _____

This page must be signed ONLY by a Health Care Provider or their authorized representative.

Health Care Provider's Name (Print): _____

Provider's Signature: _____ Date: ____/____/_____

Address: _____

Phone Number: _____ Fax Number: _____