UNMC Annual PPD and Flu Form

Phone: 402-559-7204 Fax: 402-559-8118

Print Name: _____ Today's Date: _____

NU ID: _____ Date of Birth: _____

TB Screening History:		
Have you ever had a reaction to a TB Skin Test?	No ❑	Yes ❑
If Yes, was medication prescribed for you?	No ❑	Yes ❑
If yes did you complete the medication ?	No ❑	Yes ❑
Have you had unprotected Face to face contact with anyone known to have tuberculosis?	No ❑	Yes ❑
Do you have any health problems that affect your immune system?	No ❑	Yes ❑
Are you taking steroids or anti-cancer medication/treatment?	No ❑	Yes ❑
If "Yes" to either of the health history questions, contact Student Health prior to obtaining a TB Skin Test		
Pulmonary Symptom Review		
Had a persistent cough that lasted more than three (3) weeks?	No ❑	Yes ❑
Coughed up any blood?	No ❑	Yes ❑
Fever?	No ❑	Yes ❑
Weight Loss?	No ❑	Yes ❑
Night sweats?	No ❑	Yes ❑
Weakness or Fatigue?	No ❑	Yes ❑
If "Yes" to any of the above symptoms, contact Student Health Immediately		

Flu Vaccine Screening and Consent		
Do you feel sick today?	No ❑	Yes ❑
Have you ever had Guillain-Barre Syndrome?	No ❑	Yes ❑
Have you ever had an allergic reaction to eggs?	No ❑	Yes ❑
If Yes, please describe the reaction.		
Have you ever had a reaction to a flu shot before?	No ❑	Yes ❑
If Yes, please describe the reaction.		
Are you allergic to latex or do you have a latex sensitivity	No ❑	Yes ❑

For Staff Use Only:

Flu Vaccine Detail		
Vaccine Date:		
Vaccine Site:	Left Deltoid ❑	Right Deltoid ❑
Administered By:		
Flu Vaccine Lot Detail:		
Manufacturer:		
Lot #:		
Exp Date:		

For Staff Use Only:	**Given By:**
Date Given:	**Lot #:**
Time Placed:	**EXP Date:**
Administration Site:	Left Forearm ❑ Right Forearm ❑

Date of Read:	Read By:
Time read:	
❑ NEGATIVE	mm of Induration
❑ INDETERMINATE*	mm of Induration
If results are indeterminate or positive, employee must report to Student Health immediately	

I have read the information on this form. I have received a copy of the current Immunization Information Sheets, and have had a chance to ask questions. I understand the benefits and risks, and accept responsibility for any complications resulting from receiving the vaccine. I authorize Student Health to report my immunization status to my designated coordinator and/or the Department of Epidemiology, I agree to have my vaccination information logged for tracking purposes and input into a computer generated medical record (EMR).

	No ❑	Yes ❑
Signature:		
Date:		