UNMC STUDENT HEALTH TB SCREEN CARD
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 test? If	No ❑	Yes ❑
yes, was medication prescribed for you?	No ❑	Yes ❑
If yes, did you complete the medication?	No ❑	Yes ❑
Have you received a BCG vaccine in the last 10 years? *(BCG, a vaccine made of a live weakened strain of the TB bacteria. Is used in many countries but not in the United States)*	No ❑	Yes ❑
Have you had unprotected face to face contact with anyone known to have tuberculosis?	No ❑	Yes ❑

HEALTH HISTORY
(Information below must be obtained prior to TB skin test):

Do you have any health problems that affect your immune system?	No ❑	Yes ❑
Are you taking steroids or anti-cancer medications/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 (in the first 6 months, have you had any unexplained persistent symptoms of):

Had a persistent cough that lasted more than 3 weeks?	No ❑	Yes ❑
Coughed up any blood?	No ❑	Yes ❑
Fever?	No ❑	Yes ❑
Weight loss?	No ❑	Yes ❑
Night sweats?	No ❑	Yes ❑
Weakness of Fatigue?	No ❑	Yes ❑

If "yes" to any of the above symptoms, contact 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, agree to have my vaccination information logged for tracking purposes and input into a computer generated medical record (EMR).

Signature_____ **Date**_____

FOR STAFF USE ONLY:

#1 GIVEN AT:
❑ Student Health appointment
❑ Offsite
❑ Student Health Open Clinic

DATE GIVEN_____
TIME PLACED_____
BY _____
LOT #_____
EXP DATE_____

SITE:
LEFT ARM ❑ RIGHT ARM ❑

DATE READ_____READ BY_____

TIME READ_____

❑ NEGATIVE SIZE OF INDURATION_____mm
❑ POSITIVE* SIZE OF INDURATION_____mm
❑ INDETERMINATE* SIZE OF INDURATION_____mm

2 STEP NEEDED? YES ❑ NO ❑

FOR STAFF USE ONLY:

#2 GIVEN AT:
❑ Student Health appointment
❑ Offsite
❑ Student Health Open Clinic

DATE GIVEN_____
TIME PLACED_____
BY _____
LOT #_____
EXP DATE_____

SITE:
LEFT ARM ❑ RIGHT ARM ❑

DATE READ_____READ BY_____

TIME READ_____

❑ NEGATIVE SIZE OF INDURATION_____mm
❑ POSITIVE* SIZE OF INDURATION_____mm
❑ INDETERMINATE* SIZE OF INDURATION_____mm

2 STEP NEEDED? YES ❑ NO ❑

***If results are indeterminate or positive, employee must report to Student Health immediately**

FLU SHOT:

Flu Shot Consent
Do you feel sick today? No ❑ Yes ❑
Have you had Gillain-Barre Syndrome? No ❑ Yes ❑
Have you ever had an allergic reaction to chicken eggs? No ❑ Yes ❑
Have you ever had a reaction to a flu shot before? No ❑ Yes ❑
Are you allergic to Thimerosol (Merthiolate) or Mercury? (Contact Lens Solution)? No ❑ Yes ❑
Are you allergic to latex or do you have a latex sensitivity? No ❑ Yes ❑

Flu Vaccine Detail ***FOR STAFF USE***
Vaccine Date: _____
Vaccine Site: _____
Administered By: _____

Flu Vaccine Lot Detail
Manufacturer: _____
Lot #:_____ Exp. Date: _____

I authorize Employee Health/Student Health to report my immunization status to my manager and/or the Department of Epidemiology. No ❑ Yes ❑