SUNY ADIRONDACK
Health Sciences Division - Nursing Program
Health Form

Banner ID: _____

Individual's name: _____ DOB: _____/_____/_____

Tuberculin Skin Test:
A two-step TB Skin Test or a documented history of a two-step TB Skin Test is required with one exam completed with a negative reading and a retest within 7-21 days.

A. **Last PPD Skin Test** □ Aplisol □ Tubersol

Date Placed ___/___/___ Date Read ___/___/___ Results _____ mm _____

B. **2 Step TB Skin Test** #1 Date Placed ___/___/___ Date Read ___/___/___ Results: _____

#2 Date Placed ___/___/___ Date Read ___/___/___ Results: _____

Conversion Date _____/____/_____ Clinical follow-up was done □ yes □ no

Clinical follow-up was done where_____

C. History of a negative **CXR**, please fill out the Annual Screening information on the other side of this form.

D. Negative **QuantiFERON®-TB** test per CDC recommendation Date ___/___/_____ Results _____

Rubella*: (German measles) # 1Vaccine given Date ___/___/___ # 2Vaccine given Date ___/___/___ **Or Positive Rubella*** titer Date ___/___/___

Rubeola*: (Measles) # 1Vaccine given Date ___/___/___ # 2Vaccine given Date ___/___/___ **Or Positive Rubeola*** titer Date ___/___/___

Mumps* #1 Vaccine given Date ___/___/___ #2 Vaccine given Date ___/___/___ **Or Positive Mumps*** titer Date ___/___/___

MMR Vaccine #1 Date ___/___/___ MMR #2 Date ___/___/___
*Acceptable MMR vaccines are those given after 1968.

Hepatitis B Vaccine (series of 3)
Dates #1 ___/___/___ #2___/___/___ #3___/___/___ **Or** Series completed ___/___/___

Varicella Vaccine Dates #1 ___/___/___ __ #2 ___/___/___ **Or** Positive **Varicella** titer Date ___/___/___

TDAP Date ___/___/___ **Or TD** per MD Recommendation Date ___/___/___
(Tetanus, Diphtheria, Pertussis)

Influenza (According to the CDC) *Vaccine given prior to June 30th is intended for the previous flu season. Vaccine given after August 1st is intended for the upcoming flu season. The HSD requires documented proof of immunization or signed declination by November 1st for students starting the fall semester and prior to beginning classes for students starting in the spring semester.

Date ___/___/___ **Lot Number** _____ **Manufacturer** _____ **Expiration Date** ___/___/___

Continue →

TB Annual Screening Tool

The above-mentioned person has a history of a positive reaction to a PPD and is unable to receive another PPD for the purpose of screening for TB.

Chest X-ray

Date: _____ Result: _____ Treatment: _____

Symptoms:

	Yes	NO	Comments
Fever	☐	☐	_____
Night Sweats	☐	☐	_____
Fatigue	☐	☐	_____
Cough	☐	☐	_____
Malaise	☐	☐	_____
Weight Loss	☐	☐	_____

***Chest X-ray should be done if cluster of symptoms are present.**

Recent Exposure to a TB Case: ☐YES ☐NO

Comments:_____

_____

_____

☐ Rescreen for symptoms in a year.

☐ Client to report onset of symptoms (above) to primary care provider and remind provider of positive PPD status.

☐ Refer for chest x-ray because TB symptoms are noted at time of screening.

Date: _____ Result: _____

☐ Other: _____

Medical records for above information are retained in the below physician's office.

The above named individual is in good physical and mental health and is free from any condition which poses a potential risk to patients, hospital personnel or self. They may attend school and clinical without limitations.

_____ (Date) _____

Physician Signature (NP or PA acceptable)

_____

Printed Name