

University of Miami School of Nursing and Health Studies
ANNUAL TUBERCULOSIS SCREENING & TESTING FORM

Name _____ UM Student # _____
Last First M. I.

1. History of prior positive PPD Yes No

If yes :

Chest X-ray Normal Abnormal _____
month date year

(copy of chest X-ray report must be attached to this form, unless previously submitted)

If PPD was positive and chest X-ray was negative: Was treatment of latent Tb offered? Yes No

Was treatment of latent Tb accepted? Yes No

Details of treatment including drug, dose, frequency and duration:

Name & title of physician or health care provider Signature Date

If no :

Annual PPD Screening Result

PPD (Mantoux 5TU only) date placed _____ date read _____
month date year month date year

Positive Negative _____ mm induration _____
month date year

2. Symptom Review:

Do you have any of the following?

Cough (duration of 3 wks or more)	yes _____ no _____	Night Sweats	yes _____ no _____
Chest Pain	yes _____ no _____	Appetite loss	yes _____ no _____
Hemoptysis (coughing up blood)	yes _____ no _____	Weight loss	yes _____ no _____
Fever	yes _____ no _____	Fatigue	yes _____ no _____
Chills	yes _____ no _____		

Signature of Student Date

Name & title of physician or health care provider Signature Date

Address

City State Zip Telephone

ENTER INFORMATION at mystudenthealth.miami.edu and return completed form to: **Student Health Service**
5513 Merrick Drive, Coral Gables, FL 33146 Fax (305) 284-6463 studenthealth@miami.edu

Immunization information is provided to the State of Florida FLORIDA SHOTS immunization registry. Students can opt-out of this immunization registry by completing an opt-out form, available at www.miami.edu/student-health

VERIFICATION OF RECEIPT AND PROCESSING CAN BE OBTAINED at www.mystudenthealth.miami.edu