Annual Tuberculosis Symptom Review Form

This form is required *only* of those with a history of positive PPD or other positive TB test result

Submit directly to the Compliance Office: A105

Fax to: 617-690-3730 *(secure fax)*

Email to: laboure_compliance@laboure.edu

Student name ➢______________________________

Date of Birth ➢______________________________

Student ID ➢______________________________

Are you exhibiting any of the following symptoms of TB now, or within the past 12 months?

Yes	*No*	
☐	☐	Fever?
☐	☐	Night Sweats?
☐	☐	Chronic fatigue?
☐	☐	Coughing up blood?
☐	☐	Involuntary weight loss?
☐	☐	Cough lasting longer than 3 weeks?

If you answered "yes" to any of the above symptoms, please explain how the symptoms began and how long they lasted.

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Have you ever had an x-ray done to rule out TB? If yes, when the x-ray was done.

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Have you been treated for TB? If yes, what was the treatment and when?

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This symptom review is valid of one year. Please complete and submit yearly.

Print name: ______________________________

Signature: ______________________________ **Date:** ______________