Napa Valley College
Student Health Services
2277 Napa-Valley Highway
Napa, CA 94558
(707) 256-7780

Tuberculosis Screening Consent

Circle One: Student Staff Faculty

Name: _____ Age: _____ Date: _____

ID Number #: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

Phone #: _____ Email: _____

Please answer the following questions and check appropriate response:

	YES	NO	Unknown	Year
Have you EVER had a TB (PPD) skin test?				
If yes, was there a reaction?				
Is there a history of TB in your family?				
Have you ever taken Anit-Tuberculin medications?				
Have you ever had "BCG" vaccination?				
Have you had an MMR vaccine in the past 4 weeks?				
Do you currently have an immune compromised illness?				

If you have had a previous positive skin test, please bring a copy of Your previous chest x-ray results to NVC Student Health Services for clearance. Date / Results: _____

Do you currently have any of the following symptoms?	**YES**	**NO**	**Unknown**
Unusual fatigue for more than 2 weeks?			
Weight loss (unrelated to dieting)?			
Loss of appetite for more than 2 weeks?			
Persistent cough longer than 2 weeks?			
Blood streaked sputum?			
Fever associated with cough for more than 1 week?			
Night sweats?			
Other unusual symptoms:			

Explain: _____

*****Certain medical conditions may cause a TB skin test to be negative, even when TB infection is present.*****

I agree to have a Tuberculosis Screening Skin Test: _____
(Signature)

0.1 ml / 5 TU PPD Mfg: _____

Lot # _____Exp: _____

Admin. Date: _____ Time: _____

By: _____

Forearm Site: R L

Date Read: _____

By: _____

Interpretation of Results

Non-Reactive Reactive: _____mm ind.

Chest X-Ray Referral: _____
Clearance Given Pending