FIU FLORIDA INTERNATIONAL UNIVERSITY

TB Annual Health Screening Form
College of Nursing and Health Sciences

Name ____ **Date** ________________________

Panther ID Number __________________________________ **Phone Number** __________________

Program of Study ____________________________________

Section A - Student

Answer the following questions by Checking ✔ Yes or No

1. Unexplained productive cough ☐ Yes ☐ No
   Cough greater than 3 weeks in duration
2. Unexplained fever ☐ Yes ☐ No
   Persistent temp elevations greater than one month
3. Night sweats ☐ Yes ☐ No
   Persistent sweating that leaves sheets and bedclothes wet
4. Shortness of breath/Chest pain ☐ Yes ☐ No
   Presently having shortness of breath or chest pain
5. Unexplained weight loss/appetite loss ☐ Yes ☐ No
   Loss of appetite with unexplained weight loss
6. Unexplained fatigue ☐ Yes ☐ No
   Very tired for no reason

The above health statement is accurate to the best of my knowledge. I will see my doctor and/or the health department if my health status changes. I understand I must have a current chest X-ray within the past 5 years.

____ ______/_____/_____
Student Signature Date

Section B - Clinician

I have examined _______________________. This person has no signs or symptoms suggestive of active tuberculosis disease. A repeat chest X-ray for tuberculosis is not indicated at this time.

____ ______/_____/_____
Clinician Signature Date

____
Printed Name

Medical Office Stamp