Annual Tuberculosis (TB) Screening

Self Declaration

Aug 2022

This form must be completed **AFTER MAY 1ST** (NO SOONER) and submitted by **JULY 31ST** at the latest.

Instructions for submission are on the Health Screening website: https://fhs.mcmaster.ca/healthscreening/formsandsubmission.html

Health Screening Office contact: 905-525-9140 ext 22249, hrsadmin@mcmaster.ca

Student name (last): _____ **(first):** _____ **Program:** _____

1. ☐ PLEASE READ THE FOLLOWING FIRST: TB Risk Assessment and TST Conversion

2. Check your records for the result of the LAST tuberculin skin testing (TST): ☐ Negative – Go to A ☐ Positive – Go to B

A. SINCE YOUR LAST NEGATIVE TST HAVE YOU:

Traveled outside Canada for one or more months which meets the criteria for TB testing; OR been notified by Occupational Health or Public Health that you had significant exposure to an individual with active TB disease.

☐ **NO THIS DOES NOT APPPLY TO ME**

Please sign & date Section 3 below and submit. A TB test is NOT required.

NOTE: Some placement sites may require a more recent test; students are responsible to be aware of the placement site requirements.

☐ **YES THIS APPLIES TO ME**

Provide documentation of TST given eight or more weeks post-exposure. Use Section 4 below or attach fully documented TST.
** IF RESULT IS POSITIVE, GO TO B. **
** IF RESULT IS NEGATIVE, sign & date Section 3 below and submit **

NOTE: TST must be given and read before OR given at least 28 days after a live vaccine (MMR, Varicella).

B. IF YOUR LAST TST WAS POSITIVE: Answer both of the following:

Is this a NEW positive test not previously reported to the Health Screening Office?

☐ No – Repeat chest x-ray is not required unless symptoms of active TB disease are present.

☐ Yes – You must withdraw from clinical activities and report the positive result to your Program Manager and the Health Screening Office immediately. Provide documentation of the positive TST and a chest x-ray report.

Do you currently have any symptoms of active TB disease? Symptoms include persistent cough or fever lasting three or more weeks, hemoptysis (coughing up blood), night sweats, unexplained or involuntary weight loss.

☐ No

☐ Yes – You must withdraw from clinical activities and seek prompt medical attention. Letter from a physician required.

Please sign & date Section 3 below and submit.

3. Student signature: _____ **Date:** _____

4. This section may be completed by a qualified health care professional (HCP) to document NEW TST **if required.**

Date TST given (Year/Month/Day)	Date TST read (Year/Month/Day)	mm induration	Interpretation	HCP Initials

HCP Name: _____

Profession: _____ Initials _____

Signature: _____

Date: _____

Office stamp or Address/Telephone