Annual Tuberculosis (TB) Screening

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/forms and submission.html](https://fhs.mcmaster.ca/healthscreening/forms and submission.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. LAST TST NEGATIVE:**

   Does either of the following apply to you SINCE THE LAST NEGATIVE TST above:  Travel outside Canada for one or more months which meets the criteria for TB testing; OR notified by Occupational Health or Public Health that you had significant exposure to an individual with active TB disease?

   □ No – Updated TST is NOT required by the Health Screening Office. **NOTE:** Some placement sites may require a more recent test; students are responsible to be aware of the placement site requirements.

   □ Yes – Provide documentation of TST given eight or more weeks post-exposure. **IF RESULT POSITIVE, GO TO B**

   **B. LAST TST POSITIVE:**

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

   □ No

   □ 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 persistent symptoms of active TB disease? Symptoms include: Cough lasting three or more weeks; hemoptysis; shortness of breath; chest pain; fever; chills; 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.

3. **Student signature:** ___________________________________________  **Date:** __________________________

This section may be completed by a qualified health care professional (HCP) to document NEW TST:

<table>
<thead>
<tr>
<th>Date TST given (Year/Month/Day)</th>
<th>Date TST read (Year/Month/Day)</th>
<th>mm induration</th>
<th>Interpretation</th>
<th>HCP Initials</th>
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HCP Name: _______________________________ Profession: __________________ Initials __________

HCP signature: ___________________________  **Date:** __________________________

Address/Telephone: _______________________________________________________________

+/- Office stamp