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

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 – 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.

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

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

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

HCP Name: _____ Profession: _____ Initials _____

HCP signature: _____ Date: _____

Address/Telephone: _____

+/- Office stamp