Annual Health Self Assessment and Mandatory Tuberculosis Screening

ST. GEORGE'S UNIVERSITY SCHOOL OF MEDICINE
PART IV - ANNUAL HEALTH SELF ASSESSMENT AND MANDATORY TUBERCULOSIS SCREENING

Name: _____ Telephone Number_____
Address_____
Social Security No. _____
E-Mail Address _____
Notify in case of Emergency:_____
Address: _____
Telephone Number: _____

A. EVIDENCE OF TUBERCULIN SCREENING COMPLETED WITHIN THE LAST THIRTY DAYS

1. TUBERCULOSIS SCREENING: Intermediate PPD (5TU Mantoux Test)
Date: _____ Product Name_____ Lot No: _____
Result: _____mm. (Please indicate mm of induration)

PHYSICIAN OR REGISTERED NURSE SIGNATURE: _____
License #: _____

If your PPD is positive (>10mm) now or by history, the following statement must be signed by a physician and submitted. Students with a history of BCG vaccination or anti-tuberculosis therapy are not excluded from this requirement.

2. I have been asked to evaluate the above named student because of a positive PPD. Based on the student's history, my physical exam and recent chest X-ray (date_____)

I certify that the student is free of active Tuberculosis and poses no risk to patients.

Date_____Physician Signature: _____Lic. # _____

B. SELF ASSESSMENT HEALTH FORM

Has there been any major change in your health status during the past year? Yes_____ No_____
If yes, explain: _____
_____

Have you had any illnesses, accidents, operations or injuries during the past twelve months?
Yes _____No_____ If yes, Explain _____
_____

Were you hospitalized for any medical, surgical or psychiatric problems during the last 12 months? Yes____ No_____ if yes, please specify _____

Do you have any significant problems with your health at the present time? Yes_____ No_____
If yes, please specify _____

_____

Are you taking any medications on a regular basis? Yes ____ No ___ If yes, please specify _____
_____
_____

Do you use drugs or substances which alter behavior? Yes___ No___ If so, please specify _____
_____

In the past 12 months have you had any of the following?

	Yes	No		Yes	No
Cough			Sore Throats		
Fevers			Skin Infections		
Night Sweats			Rash		
Weight Loss			Nausea		
Shortness of Breath			Vomiting		
Hemoptysis			Diarrhea		

If YES to any of the above, please explain details and current status _____
_____
_____
_____

I declare that I have had no injury; illness or health condition other than specifically noted above and will notify St. George's University School of Medicine of any changes in my health status.

Date: _____ Student Signature:_____

After completion of this form, it must be scanned into PDF image and email to the following

ClinicalHealthForms@sgu.edu