The Christ Hospital™ Health Network

TB Screening Questionnaire

Name (Print): ____ _______ **Junior Volunteer**__________

Dept: _________**VOLUNTEER SERVICES**______________________ Date:_________________________

1. Do you have a history of a positive TB Skin Test or history of having TB? Yes No
2. Do you now have any condition requiring prolonged steroid or immunosuppressive therapy? Yes No
3. Do you have an immunosuppressive illness at the present time? Yes No
4. Have you had any of the following in the past year?
   - Recent, close contact with any person having active tuberculosis? Yes No
   - Unexplained productive cough? Yes No
   - Coughing up blood? Yes No
   - Unexplained weight loss or increased fatigue? Yes No
   - Unexplained fever or night sweats? Yes No
5. Have you had the BCG vaccine? Yes No
   (Vaccine given in foreign countries where there is a high incidence of Tuberculosis)

Volunteer Signature ____

I hereby consent to the QuantiFERON GOLD, a TB blood test. I grant permission for the information contained in this form to be shared with other health systems for the purpose of education.

Volunteer Signature ____

Parent Signature ____Mother / Father________

Employee Health Department

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