

Pre-Employment    Volunteering    Annual    Exposure    Credential    Other \_\_\_\_\_

**First Name** \_\_\_\_\_

**Last Name** \_\_\_\_\_

**Department** \_\_\_\_\_

**Position** \_\_\_\_\_

1. Have you had any of the following symptoms during the past year for more than two weeks, **NOT** associated with a specific illness?
- |                                                  | No                       | Yes                      | ?                        |
|--------------------------------------------------|--------------------------|--------------------------|--------------------------|
| a. Chest Pain                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Chills                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Chronic cough (lasting greater than 3 weeks)  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Coughing up phlegm or blood                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Difficulty breathing or wheezing              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Fatigue/Weakness                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Fever, usually at night                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Loss of appetite                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Unexplained weight loss of more than 5 pounds | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

*If you develop any Tuberculosis symptoms mentioned above, call Employee Health as soon as possible.*

- |                                                                                                                 |                          |                          |                          |
|-----------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| 2. Have you received oral polio vaccine in the past 4 to 6 weeks?                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you received the MMR vaccine in the past 4 to 6 weeks?                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you receiving corticosteroid or other immunosuppressive therapy?                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you sensitive or allergic to the PPD serum?                                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Were you ever vaccinated against Tuberculosis (BCG <sup>1</sup> - <i>Bacillus Calmette-Guérin</i> )?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have a history or ever had a <b>Positive</b> skin test?                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever been diagnosed or treated for Tuberculosis?<br>If yes, which medication did you receive? _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. <del>Females</del> —Are you pregnant?                                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Instructions:** If applicable, you will be given a Tuberculosis skin test that must be read within 48 to 72 hours. If not read, it will be considered invalid and will have to be repeated.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE!**

**#1 HAVE READ 48 to 72 HOURS AFTER PLANT DATE**

Plant date of PPD skin test \_\_\_\_\_ Planted by \_\_\_\_\_  
 Site Planted    LFA    RFA    LUA    RUA  
 Date PPD site was read \_\_\_\_\_ Read by \_\_\_\_\_  
 Induration \_\_\_\_\_ mm                      Erythema \_\_\_\_\_ mm  
 Comments \_\_\_\_\_  
 Manufacturer:    Connaught    Parkdale    Adventis Pasteur  
 Lot Number :   Expiration Date: \_\_\_\_\_

**#2 HAVE READ 48 to 72 HOURS AFTER PLANT DATE**

Plant date of PPD skin test \_\_\_\_\_ Planted by \_\_\_\_\_  
 Site Planted    LFA    RFA    LUA    RUA  
 Date PPD site was read \_\_\_\_\_ Read by \_\_\_\_\_  
 Induration \_\_\_\_\_ mm                      Erythema \_\_\_\_\_ mm  
 Comments \_\_\_\_\_  
 Manufacturer:    Connaught    Parkdale    Adventis Pasteur  
 Lot Number :   Expiration Date: \_\_\_\_\_

<sup>1</sup> This vaccine contains live bacteria, a harmless strain related to the TB bacteria. It gives about 70% protection, and although this is not as good a level of protection as one may wish, it is still far better than nothing and makes this vaccine absolutely essential. It is a very safe vaccine if given with care by qualified persons. Adverse effects including abscesses and large scars are mainly due to faulty techniques. Very severe adverse effects are virtually unknown.

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