



Medical Technology Department

TB Screening Requirements

The Medical Technology Department of Armstrong Atlantic State University requires screening for tuberculosis and follow-up for reactions $\geq 10\text{mm}$ of all students in program. Requirements are based on current recommendations of the Centers for Disease Control and Prevention (CDC) for health care workers. Pregnancy does not exclude students from annual TB screening.

I. Screening for Entering First Year Students

All incoming Medical Technology students will be required to be screened for tuberculosis (TB). Screening for students is the following:

A single Mantoux (PPD) skin test will be administered. The Mantoux skin test must be read and recorded by a licensed healthcare provider within 48-72 hours prior to student attending school.

A history of Bacillus of Calmette and Guerin (BCG) is not grounds for waiving screening.

A reaction $\geq 10\text{mm}$ will be considered positive.

Students who have documented prior history of a positive TB skin test or who test positive ($\geq 10\text{mm}$) in their initial TB screening must provide documentation ruling out active disease.

If student cannot provide documentation of chest radiograph within past year, one must be obtained. If student can provide documentation of radiograph within past year, student does not need to repeat radiograph. Student must have licensed healthcare provider fill out TB Screening Questionnaire (attached) and return it to the Medical Technology program. If information obtained in the questionnaire reveals symptoms suggestive of TB, the student must undergo a medical evaluation including a chest radiograph and follow up treatment as indicated. Students with positive skin tests will be required to be screened annually using the TB questionnaire.

II. Annual Screening for Second Year Students

Students who have no prior history of a positive ($\geq 10\text{mm}$) tuberculin skin test should be screened annually with a PPD.

Student with positive skin tests are required to have licensed healthcare provider fill out TB Screening Questionnaire annually.

No student will be permitted to participate in Clinical Rotations until screening and follow up requirements have been met.



TB Screening Questionnaire

Confidential

Last Name _____ First Name _____ MI _____

Date of Birth _____ Student ID # _____

Email _____ Phone Number _____

Date of last PPD: _____ Result (**Circle one**): Negative Positive

Date of last chest x-ray: _____

I have/have not taken (**Circle one**) medication to treat TB in the past.

Name of medication: _____ Dosage: _____ Duration of treatment: _____

1. Since your last TB review, have you worked in a location where patients with active TB received care of services? (**Circle one**) Yes No
2. Since your last TB review, have you lived with or had close contact with someone who has TB disease? (**Circle one**) Yes No
3. Since your last TB review, have you had an abnormal chest x-ray? (**Circle one**) Yes No
4. Since your last TB review, has a health practitioner told you that your immune system isn't working right or can't fight infection? (**Circle one**) Yes No
5. Do you work, volunteer, or live in another facility that provides medical or social services? (**Circle one**) Yes No
6. Since your last TB review, have you traveled outside the USA? (**Circle one**) Yes No
7. Since your last TB review, have you had any of the following symptoms for more than 3 weeks at a time? (Check all that apply)

<input type="checkbox"/> Persistent coughing	<input type="checkbox"/> Excessive fatigue	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Excessive sweating at night	
<input type="checkbox"/> Persistent fever	<input type="checkbox"/> Excessive weight loss	

Assessment: _____

Plan: _____
Verbalizes understanding of follow-up instructions and recommendations
Other: _____

Healthcare Provider Signature: _____ Date: _____

I certify that, to the best of my knowledge, the above statements concerning my medical assessment are true. I realize this assessment does not replace care by my family physician. I understand if a medical referral is required, my condition changes, or new symptoms appear, I will contact my family physician immediately.

Student _____ Date _____