

Texas Woman's University
Tuberculosis (TB) Screening Requirement Form

Please answer the following questions. Select Yes or No. Provide additional details where indicated.

Have you received a measles, mumps, rubella (MMR) or chicken pox (Varicella) vaccine in the last 4-6 weeks? Yes No

Were you born in the United States? Yes No

What country were you born in? _____

How long have you lived in the United States? _____

Have you ever lived in a country outside the US? Yes No

Please list all countries you have lived in: _____

Have you ever traveled to any country outside of the United States and stayed longer than 8 weeks? Yes No Please list countries you have traveled to: _____

Have you ever had a TB Blood test? Yes No

Have you ever had a positive TB test? Yes No Type of test: _____

Did you have a chest x-ray? Yes No Results of chest x-ray: _____

Did you take antibiotics for TB? Yes No

How long did you take the TB antibiotics? _____

Did you take the full amount of TB antibiotics? Yes No

Have you had close contact with persons known or exposed to TB? Yes No

Have you been a volunteer, employee or resident in a correctional facility, long-term facility or homeless shelter? Yes No

Are you taking any immunosuppressive medication such as steroids (prednisone), biologicals (such as Humira), or chemotherapy? Yes No

Do you have, or have you had in the past, cancer, leukemia, diabetes, kidney disease, or HIV/AIDS? Yes No When? _____

Have you ever been told you have an atypical mycobacteria infection? Yes No

Were you ever given BCG (Bacille Calmette-Guerin) vaccine? Yes No

Student Information

TWU Student ID #: _____

Student Name: _____

Date of Birth: _____

Student Signature: _____ Date: _____

This form and TB result record must be uploaded to the TWU Patient Portal.

For assistance, please contact TWU Student Health Services at (940) 898-3825 or email Immunization@twu.edu.