The UNIVERSITY of VERMONT
COLLEGE OF NURSING & HEALTH SCIENCES

Name _____
Student ID# _____
Date of Birth _____
Program/Graduation Year _____
Phone# _____
Email _____
Date _____

TB Symptom Checklist

TO BE COMPLETED ANNUALLY IF HISTORY OF POSITIVE PPD
Make an appointment with your health care provider. Take this form to your appointment.

In the past six months have you experienced any of the following for greater than six weeks?		
Excessive sweating at night	yes	no
Excessive weight loss	yes	no
Persistent coughing	yes	no
Excessive fatigue	yes	no
Coughing up blood	yes	no
Hoarseness	yes	no
Persistent Fever	yes	no
	Circle Result:	
TB Symptom Check	pos	neg

Licensed Health Care Provider Attestation

By signing below, I affirm that I am a licensed health care provider. I am aware that leaving any required fields blank will result in the student being **unable to progress in his/her major** at the University of Vermont.

_____ _____ _____
Signature of **Licensed Health Care Provider** **Credentials** Date

_____ _____
Clinic Stamp or Printed Name of Provider Provider Telephone Number

It is MANDATORY that you scan and upload ALL Pages of the form to CastleBranch.

Please note, UVM Student Health will not submit your paperwork for you. You will need to pick up your documents and submit them to CastleBranch.

The information included on this form maybe released to the infection control officer and clinical education coordinators at sites where you perform your clinical education experience.