Annual Health Screening Questionnaire

Instructions: Annual symptom screening is required for some students who have a history of negative Q Gold or IGRA. Students are required to complete this form yearly, if pertinent, or if they have potential risk due to travel.

Have you left the USA in the past year? ____

Do you CURRENTLY have symptoms of:

	YES	NO
Weight loss (unrelated to dieting)	☐	☐
Loss of appetite for >2 weeks	☐	☐
Bloody sputum	☐	☐
Night sweats/fever	☐	☐
Unusual fatigue for > 2 weeks	☐	☐
Persistent cough > 2 weeks	☐	☐

Answering "yes" to any of the above questions constitutes a positive screening evaluation and requires further follow-up with your health care provider.

I am aware that misrepresentation of health information may result in dismissal from the program. I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Signature____ **Date**_______________________

Print Name ______________________________________ **Student ID#**_________________

Health Care Provider verifying information [THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER] Nurse Practitioner, Physician, Registered Nurse, Physician's Assistant or a public health official	
Name of Health Care Provider [Print]	**Telephone [area code + number]**
Signature of Halth Care Provider	**Date**
Address of Health Care Provider	