Chaffey College
Student Health Services
(909)652-6331

Employee TB Risk Assessment Clearance Form

____
Employee name (print): Last, First

____
ID number

____
Date of Birth

❑ New Employee ❑ Returning Employee Department: ____________

PLEASE READ AND MARK CORRECT RESPONSE TO THE FOLLOWING QUESTIONS:

1. Have you ever had a TB skin test? _______Yes _______ No

2. Were you ever told you have had a positive reaction and that you were required to get a chest x-ray?
   ______Yes ______No

3. If you had a chest x-ray What year?____________ Was it in normal range___________

4. Did you receive an immunization called BCG (immunization to prevent TB, not used in the US)? ______Yes _________ No

5. Do you currently have any of the following symptoms:
   Night Sweats Chronic _____yes ______no
   Elevated Temp _____yes ______no
   Chronic cough(productive/non-productive) _____yes _____ no

I HAVE READ AND UNDERSTAND THE CHAFFEY COLLEGE STUDENT HEALTH SERVICES HIPPA NOTICE OF PRIVACY PRACTICES, AND HAVE BEEN GIVEN A PERSONAL COPY FOR MY RECORDS.

______________________ ______________________________________
Date Signature

STUDENT HEALTH OFFICE USE ONLY

Date: ____________ Time: ___________

❑ Denies history of positive skin test reaction.

❑ Informed consent signed

❑ History of positive Tuberculin skin test/year________________

❑ Chest x-ray: ____ no ____ yes ________WNL

❑ Referred to PMD for possible new chest x-ray due to:___________________

❑ Denies night sweats

❑ Denies chronic elevated temp

❑ Denies chronic cough (nonproductive/productive)

_____Yes ______ No......Eligible for Employee TB Clearance Certificate

Referred for actual skin test due to:_______________

______ Date emailed TB Clearance Certificate

RN signature: ________________________ Date: ____________