NICHOLLS STATE UNIVERSITY
University Health Services

Tuberculosis Symptom Screen

Please check any of the following symptoms that you have experienced within the last year:

_____ Coughing (not related to the common cold)

_____ Coughing up blood

_____ Shortness of breath

_____ Chest pain

_____ Night sweats

_____ Unexplained weight loss

_____ Loss of appetite

_____ None of the above

Please write a brief explanation of any symptom(s) checked above.

_____

_____

_____

By signing this statement, I am attesting that to the best of my knowledge I am free of any pulmonary (lung) or other symptoms as noted above. If at any time between now and my next tuberculosis screening test, I should develop any of the above symptoms, I will immediately contact my physician, and notify the University Health Services and my clinical course program director at Nicholls State University.

_____ _____

Name of Student (printed) Student ID number

_____ _____

Signature of Student Date