

UNIVERSITY OF FLORIDA
STUDENT HEALTH CARE CENTER
Tuberculosis (TB) Surveillance Form

Dept: _____

Name: _____

Title: _____

UFID: _____

Date of Birth: _____

NOTE: This form is for those with a history of positive TB skin test only!

Please answer all of the following questions and sign below at the *.

1. Have you had a chronic (more than four weeks):

Chest Congestion	Y	N	Hoarseness	Y	N	Fevers	Y	N
Cough	Y	N	Night Sweats	Y	N	Weight Loss	Y	N

2. Have you been exposed to TB?

(i.e. Direct contact with a person with TB in the past six (6) months?)

NO

YES

If yes, name of person (if known): _____

* _____
Signature

Date

Comments: _____

Authorized Signature

Date