HARMONY HEALTH CARE INSTITUTE, INC.

Licensed Practical Nurse Program

Annual Tuberculosis Screening for Students with Documented History of Positive PPD
(To be completed and signed by student's healthcare provider)

Student's name_____ **DOB** _____

QUESTIONNAIRES: (must complete)	**Yes**	**No**
Productive cough for more than 3 weeks	___	___
Persistent low grade fever	___	___
Decreased appetite	___	___
Shortness of breath	___	___
Unexplained weight loss	___	___
Night sweats	___	___
Swollen (neck) glands	___	___
Coughing up blood	___	___
Chest pain	___	___
History of exposure to someone with T.B Within the last 12 months	___	___

Note: A new chest X-ray documenting no evidence of Tuberculosis is required if the student answers yes to any of the above questionnaires.

Date of last Chest X-ray and result_____
_____
_____
_____

Healthcare Provider's signature_____ Date_____