Western Governors University Compliance Form
RN-BSN and MSN

WGU Annual TB Screening Form

Annual Health Screening Questionnaire for History of Positive TB Skin Test

Instructions: Annual symptom screening is required for all students who have a history of a positive tuberculosis (TB) test. Students are required to complete this form yearly ***only*** *if they have a history of a positive TB test.*

When did you have a positive TB test? _____

What is the date of your last chest x-ray? _____

Result: _____

Do you CURRENTLY have symptoms of any of the following:

	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.

Student Signature: _____ Student ID Number: _____

Student Name (Print Name): _____ Date: _____

Health Care Provider Declaration I declare I have completed a tuberculosis symptoms review on this student. I certify I am a qualified MD, ND, DO, ARNP, or PA licensed in the state of _____.		
X	**X**	
Licensed Health Care Provider Name (Print)	**Licensed Health Care Provider Signature**	**Date**
☐ **MD** ☐ **ND** ☐ **DO** ☐ **ARNP** ☐ **PA**	**Provider License #**	