TB SCREENING FORM

Name: _____ Student ID#:_____ Date: _____

School: _____ Birth date: _____/_____/_____ Phone: _____
MM DD YYYY

☐ ☐ Production of sputum – if yes, what color sputum: _____

☐ ☐ Blood-streaked sputum

☐ ☐ Unexplained weight loss

☐ ☐ Unexplained fatigue/tiredness

☐ ☐ Night sweats

☐ ☐ 4/19/Fev

Student Health Service
24785 Stewart St. Evans Hall, Ste. 111
Loma Linda, CA 92354
Phone: (909) 558-8770
Fax: (909-558-0433

TB Screening Form

PATIENT IDENTIFICATION

Name:

Birth Date:

Medical Record #: