UFHealth
SHANDS

Non-clinical Interns Tuberculosis and Mandatory Immunity Surveillance Form

Occupational Health Services

☐ UF Health Shands Hospital
☐ UF Health Shands Psychiatric Hospital
☐ ElderCare of Alachua County
☐ UF Health Physicians

Please process the below named intern for Occupational Health Screening _____ *Signature* _____ *Date* _____ *Time*

Name _____ UF ID # /Student ID #: _____

Date of birth _____ Home phone # _____

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

1. Have you ever had a **positive** TB skin test? ☐ No ☐ Yes
2. Have you ever been treated for TB or a **positive** TB skin test? ☐ No ☐ Yes
   If Yes, length of treatment _____ Name of medication _____
3. Have you had a live virus vaccine *(measles, mumps, rubella, varicella)* in the last 6 weeks? ☐ No ☐ Yes
4. Have you ever had chicken pox? ☐ No ☐ Yes
5. Have you had any of the following symptoms / signs associated with active TB?

	No	Yes
A persistent cough longer than two weeks *(especially in the presence of)*	☐	☐
Unexplained weight loss	☐	☐
Night sweats	☐	☐
Bloody sputum	☐	☐
Loss of appetite	☐	☐
Fever	☐	☐

You must be evaluated promptly if you have or develop any signs or symptoms of active Tuberculosis.

PPD must be read in 48 to 72 hours.

* _____ *Print Name* _____ *Signature* _____ *Date* _____ *Time*

_____ *If Minor, parent or legal guardian print name* _____ *If Minor, parent or legal guardian must sign* _____ *Date* _____ *Time*

Do Not Write Below This Line

☐ Pre-placement ☐ Periodic surveillance _____ *Frequency*

Skin test applied _____ / _____ _____ Results _____ / _____ _____ ☐ – ☐ +
0.1 mL ID *Date / Time* *Site* *Date / Time* *Record in mm's*

_____ *Practitioner Signature* _____ *Practitioner Signature*

☐ Previous conversion ☐ New conversion

☐ Cleared ☐ Not Cleared

_____ *Practitioner Print Name* _____ *Signature Practitioner* _____ *Date* _____ *Time*

Varicella (Chicken Pox) Titer ☐ Yes _____ *Date* _____ *Initials*

Rubeola Titer ☐ Yes _____ *Date* _____ *Initials*

Rubella Titer ☐ Yes _____ *Date* _____ *Initials*

MR# _____