

Barry University
College of Health Sciences
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TB Symptom Check List

To be completed by a licensed health care provider.

Name: _____

Date of Birth ____/____/____

Barry ID or Social Security Number: _____

Please check if the above named has had any of the following:

Yes No

	Yes	No
Previous TB skin test		
Previous Positive TB skin test		
BCG Vaccine		
Active TB		
INH (isoniazid) medication		

Has the above named experienced any of the following symptoms:

Yes No

	Yes	No
New, productive cough for than 2 weeks		
Coughing up blood		
Hoarseness lasting more than 3 weeks		
Night sweats lasting more than a week		
Fever and/or chills lasting more than 1 week		
Unintentional weight loss over the past 2 months		
Unusually/excessively tired over the past 3 weeks		

Health Care Provider

I certify the student does NOT show signs of active TB disease.

Name

Street Address

City, State, & Zip Code

Date

Signature