

G. TUBERCULOSIS SCREENING (PPD Skin Test)

1. Is the student a member of a **high-risk** group (see below) or is the **student entering the health professions?**

- No** ► No further evaluation is needed
- Yes** ► Perform PPD Skin Test within 12 months of entering Salem State
 - **A history of BCG vaccination does not preclude testing!**
 - If student has been treated for latent TB no further testing is needed – document below
 - If student has had positive PPD in the past & has not been treated for latent TB, Chest X-ray is required

2. The American College Health Association has published guidelines on TB screening of college students. Categories of **high-risk** students include:

- **Living or working** in the past 5 years in countries where TB is endemic. This includes ALL countries **EXCEPT**: American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, England, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, St Kitts and Nevis, St Lucia, Sweden, Switzerland, United Kingdom, USA, Virgin Islands, or New Zealand.
- Students with a compromised immune system: HIV infection, diabetes, chronic renal failure, leukemia, lymphoma, chronic malabsorption syndromes, prolonged steroid therapy, or other immunosuppressive disorders.
- Students **who have resided in, volunteered in, or worked in high-risk congregate settings**: prisons, nursing homes, hospitals, residential facilities for patients with AIDS, and homeless shelters.
- Using recreational injection drugs.

3. PPD Skin Test within 12 months of starting at Salem State, if student is high risk (tine or monovac not acceptable)

Date read: ____/____/____ Result: _____ (Record mm of induration, transverse diameter)
Mo. Yr.

Interpretation: **Positive** _____ **Negative** _____

4. Chest X-ray (required if PPD 10mm or more, or if PPD is contraindicated)

Date performed: ____/____/____ Result: Normal _____ Abnormal _____

5. If student has had a positive PPD in the past, did they receive any treatment?

No _____ Yes _____ Medication and length of treatment _____

H. Influenza (Annual immunization recommended to avoid disruption to academic activities)

Date ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____
Mo. Yr. Mo. Yr. Mo. Yr. Mo. Yr. Mo. Yr.

G. OTHER VACCINES: _____

Health Care Provider: _____ **Telephone:** _____

Address: _____

Signature: _____ **Date:** _____

