

**\*\*\* MUST BE COMPLETED WITHIN 30 DAYS FROM DATE  
OF HIRE & ANNUALLY THEREAFTER\*\*\*  
\*\* TAKE THIS FORM WITH YOU TO YOUR DOCTOR'S OFFICE \*\***

**ARIZONA'S CHILDREN ASSOCIATION  
Fax: 520.884.5582**

**TUBERCULOSIS VERIFICATION  
MANTOUX SKIN TEST OR X-RAY**

EMPLOYEE'S PRINTED NAME: \_\_\_\_\_

\*\*\*\*\*

DATE MANTOUX SKIN TEST/X-RAY ADMINISTERED: \_\_\_\_\_

TEST/X-RAY ADMINISTERED BY:

NAME: \_\_\_\_\_

TITLE/FACILITY: \_\_\_\_\_

FACILITY PHONE NUMBER: \_\_\_\_\_

\*\*\*\*\*

**COMPLETE APPLICABLE SECTION**

DATE RESULTS VERIFIED: \_\_\_\_\_

(Mantoux Skin Test must be read within 72 hours from date administered)

MANTOUX SKIN TEST RESULTS:

NEGATIVE

POSITIVE

X-RAY RESULTS:

NEGATIVE

POSITIVE

PHYSICIAN ASSESSMENT:  (PLEASE COMPLETE PAGE 2 OF FORM)

RESULTS VERIFIED BY:

NAME: \_\_\_\_\_

TITLE/FACILITY: \_\_\_\_\_

FACILITY PHONE NUMBER: \_\_\_\_\_

## ANNUAL TUBERCULOSIS SCREENING QUESTIONNAIRE

If you have received a chest x-ray within the past 5 years to rule out the disease, please complete this screening questionnaire. This questionnaire will allow your physician to determine whether or not you are free from signs and symptoms of tuberculosis.

EMPLOYEE'S PRINTED NAME: \_\_\_\_\_

Please read and answer the following questions:

1. Have you been exposed to any patients during the course of your work in the last year who carried the diagnosis of active pulmonary tuberculosis? \_\_\_\_\_
2. Are you experiencing chronic, recurrent, intermittent fever? \_\_\_\_\_
3. Are you experience chronic, recurrent, intermittent chills? \_\_\_\_\_
4. Do you experience profuse sweating during the night (e.g. enough to require changing your night clothes)? \_\_\_\_\_
5. Do you have asthma, emphysema, or chronic bronchitis? \_\_\_\_\_
6. Do you experience wheezing? \_\_\_\_\_
7. Apart from colds, sore throats or episodic bronchitis, are you experiencing a cough which has lasted more than two weeks? \_\_\_\_\_
8. Do you cough up phlegm on more mornings? \_\_\_\_\_
9. Have you coughed up any bloody or blood-streaked sputum? \_\_\_\_\_
10. Have you had pneumonia or other serious lung disease in the last year? \_\_\_\_\_
  - i. If yes, please explain: \_\_\_\_\_
11. Has anyone close to you or in your family been diagnosed as having tuberculosis? \_\_\_\_\_
12. Do you smoke cigarettes? \_\_\_\_\_
  - i. If yes, how many cigarettes per day? \_\_\_\_\_

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**This employee is free and clear of signs and symptoms associated with tuberculosis.**

PHYSICIAN'S NAME: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_