Return immunization document to:

NDSU Student Health Service
P.O. Box 5313
Fargo, ND 58105
Fax (701) 231-6132
Phone (701) 231-6366

Student ID	______________________
Term of Enter	______________________
Comments	______________________
	______________________

OFFICE USE

Name				**Birth Date**	**Student ID or Social Security Number**
Last	First	Middle	Former		

(Social Security No. is voluntary: used for tracking purposes)

Tuberculosis Screening Documentation

All information must be in English

North Dakota State University requires documentation of tuberculosis (TB) screening within six months prior to or after college entrance with a Mantoux skin test for those students meeting the following criteria:

- Persons with signs or symptoms of active TB
- Persons with HIV infection
- Persons who have been close contacts of a person with infectious TB
- Persons who inject drugs
- Individuals with the following chronic medical conditions:
  - Diabetes mellitus
  - Leukemia or lymphoma
  - Prolonged corticosteroid therapy (>1 month)
  - Immunosuppressive therapy
- Individuals living in or who have arrived within the past five years from countries where TB is endemic. This includes all countries in:
  - African Region
  - Southeast Asia Region
  - Russia
  - Eastern Mediterranean Region

This includes all countries in the following **EXCEPT** for the countries noted, which have a low prevalence of TB:

American Region –

Saint Lucia	Canada	Virgin Islands
Jamaica	Saint Kitts & Nevis	USA

European Region –

Belgium	Denmark	Finland
France	Germany	Greece
Iceland	Ireland	Italy
Liechtenstein	Luxembourg	Malta
Monaco	Netherlands	Norway
San Marino	Sweden	Switzerland
United Kingdom		

Western Pacific Region –

American Samoa	Australia	New Zealand

Sources of documentation may be obtained from your physician, public health clinic, high school, college or military records.

Note: Transfer students must request records be sent to NDSU Student Health Service.

Is the student a member of a high-risk group? ❑ No ❑ Yes

Date Tuberculin PPD (Mantoux) given: ______/______/______ Date Tuberculin PPD (Mantoux) read: ______/______/______

Result: ____________ (record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): ❑ Positive ❑ Negative

Required signature by Health Care Provider ______________________________________ Date ______/______/______

Health Care Provider name, title and address *(please print)* ______________________________________

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