UNIVERSITY OF FLORIDA
STUDENT HEALTH CARE CENTER
Tuberculosis (TB) Surveillance Form

Name: _____ Phone: _____

UFID#: _____ Date of Birth: _____

NOTE: This form is for those with a history of positive TB skin test only!

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

1. Have you had a chronic (more than four weeks):

Chest Congestion	**Y**	**N**	Hoarseness	**Y**	**N**	Fevers	**Y**	**N**
Cough	**Y**	**N**	Night Sweats	**Y**	**N**	Weight Loss	**Y**	**N**

2. Have you been exposed to TB? (for example: Direct contact with a person with TB in the past six months?)

   NO YES If yes, name of person (if known): _____

*_____ _____
Signature Date

DO NOT WRITE BELOW THIS LINE

Comments: _____

_____

_____

_____

_____

_____ _____
Authorized Signature Date