

TB SCREENING FORM

Name: _____ Student ID#: _____ Date: _____

School: _____ Birth date: _____/_____/_____
MM DD YYYY Phone: _____

- ____ Production of sputum – if yes, what color sputum: _____
- ____ Blood-streaked sputum
- ____ Unexplained weight loss
- ____ Unexplained fatigue/tiredness
- ____ Night sweats
- ____ 4/19/Fev

Student Health Service
24785 Stewart St. Evans Hall, Ste. 111
Loma Linda, CA 92354
Phone: (909) 558-8770
Fax: (909)-558-0433

TB Screening Form

PATIENT IDENTIFICATION

Name:
Birth Date:
Medical Record #: