

ANNUAL HEALTH EXAMINATION

NOTICE: All sections must be completed and form signed.

Last Name _____ First Name _____ MI _____ PSU ID# _____

Date of Birth _____ Email Address _____ Telephone Number _____

TB STATUS:

Tuberculin Skin Test (Required Annually)

Date _____ Results: Negative Positive

If Positive TST:

Chest X-Ray Date _____
Results _____

Isoniazid Prophylaxis: No Yes
Dates _____

Are any of the following symptoms present: persistent cough, hemoptysis, night sweats, weight loss, or persistent fatigue? No Yes

Comments: _____

Health Care Provider Administering & Interpreting TST Results Must Provide the Following Information:

(Health Care Provider Printed Name) (Credentials)

Address: _____

Telephone #: _____ License # _____ State _____

Signature: _____ Date _____