

# WILLIAMS COLLEGE

**TUBERCULOSIS RISK QUESTIONNAIRE**  
**Must be completed by all students and returned with Health Report**

**NAME:** \_\_\_\_\_ **COUNTRY OF BIRTH:** \_\_\_\_\_

- |  | YES                      | NO                       |
|--|--------------------------|--------------------------|
| 1. Have you ever had a positive tuberculosis skin test? If yes go to Page 2.                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis (TB) ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Were you born in one of the countries listed below?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you traveled or lived for more than one month in any of the countries listed below?                    | <input type="checkbox"/> | <input type="checkbox"/> |

### COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)

Afghanistan	Colombia	India	Mongolia	Sierra Leone
Angola	Comoros	Indonesia	Morocco	Solomon Islands
Armenia	Congo	Iran	Mozambique	Somalia
Azerbaijan	Congo, DR	Kazakhstan	Myanmar	South Africa
Bahamas	Cote d'Ivoire	Kenya	Namibia	Sri Lanka
Bahrain	Croatia	Kiribati	Nepal	Sudan
Bangladesh	Djibouti	Korea, DPR	New Caledonia	Suriname
Belarus	Dominican Republic	Korea, Rep.	Nicaragua	Swaziland
Benin	Ecuador	Kyrgyzstan	Niger	Syrian Arab Republic
Bhutan	El Salvador	Lao PDR	Nigeria	Tajikistan
Bolivia	Equatorial Guinea	Latvia	Niue	Tanzania, UR
Bosnia & Herzegovina	Eritrea	Lesotho	Northern Mariana Islands	Thailand
Botswana	Estonia	Liberia	Pakistan	Togo
Brazil	Ethiopia	Lithuania	Palau	Tokelau
Brunei Darussalam	Gabon	Macedonia,TFYR	Panama	Turkmenistan
Burkina Faso	Gambia	Madagascar	Papua New Guinea	Uganda
Burundi	Georgia	Malawi	Paraguay	Ukraine
Cambodia	Ghana	Malaysia	Peru	Uzbekistan
Cameroon	Guam	Maldives	Philippines	Vanuatu
Cape Verde	Guatemala	Mali	Portugal	Viet Nam
Central African Republic	Guinea	Marshall Islands	Romania	Yemen
Chad	Guinea-Bissau	Mauritania	Russian Federation	Zambia
China	Guyana	Mauritius	Rwanda	Zimbabwe
China, Hong Kong SAR	Haiti	Micronesia	Sao Tome & Principe	
China, Macao SAR	Honduras	Moldova, Rep.	Senegal	

**HIGH RISK:** If the answer to Questions 2, 3, or 4 is YES, Williams College requires that you have tuberculin skin test (Mantoux test/ Intermediate PPD) to check for latent tuberculosis infection. **Your healthcare provider must complete the form on the back of this page.**

**LOW RISK:** If the answer to all the questions above is NO, a tuberculin skin test should not be done. Please disregard Page 2 of this form.

# WILLIAMS COLLEGE

## Medical Evaluation for Latent Tuberculosis Infection

(To be completed and signed by a licensed healthcare provider)

STUDENT'S NAME: \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

### PLEASE NOTE:

If student has had a positive tuberculin skin test in the past, the test should not be repeated. Go to Section B below.

#### A. TUBERCULIN SKIN TEST (Mantoux/Intermediate PPD)

Test must be read by a healthcare provider 48-72 hours after administration. If no induration, mark "0".  
Result of multiple puncture tests, such as Tine or Mono-Vac are **not accepted**.

Date test administered: \_\_\_/\_\_\_/\_\_\_ Date test read: \_\_\_/\_\_\_/\_\_\_ Result \_\_\_ mm induration

INTERPRETATION OF TUBERCULIN SKIN TEST: (Please use table below.)  Negative  Positive

RISK FACTOR	POSITIVE RESULT
Close contact with a case of tuberculosis	5 mm or more
Born in a country that has a high rate of tuberculosis	10 mm or more
Traveled or lived for a month or more in a country that has a high rate of tuberculosis	10 mm or more
No risk factors (test not recommended)	15 mm or more

#### B. If Tuberculin Skin Test is POSITIVE, now or by history, the following are required:

1. Date of positive PPD: \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

2. Chest X-ray: Required (Attach report, NOT the x-ray) \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

Normal  Abnormal \_\_\_\_\_  
Describe

3. Clinical Evaluation: \_\_\_\_\_  
 Normal  Abnormal \_\_\_\_\_  
Describe

4. Treatment: \_\_\_\_\_  
 No  Yes \_\_\_\_\_  
Drug, dose, frequency and dates

HEALTHCARE PROVIDER SIGNATURE (Required) \_\_\_\_\_ DATE: \_\_\_/\_\_\_/\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ FAX: (\_\_\_\_) \_\_\_\_\_