TUBERCULOSIS RISK ASSESSMENT

Deadline: June 30

Mail to Allegheny College, Winslow Health Center, 520 N. Main Street, Meadville, PA 16335

This form must be completed and signed by a health care provider.

<table>
<thead>
<tr>
<th>NAME: Last</th>
<th>First</th>
<th>MI</th>
<th>Date of Birth</th>
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</thead>
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Have you had close contact with anyone who was sick with tuberculosis (TB)?  
Were you born in a country with a high incidence of active TB Disease?  
Have you traveled or lived for more than a month in one of the countries with 
a high rate of TB? (Please see “high incidence” list.)  
Have you had frequent or prolonged visits to one or more of the countries with 
a high incidence of TB disease?  
Have you been a resident and/or employee of a high-risk congregate setting 
(e.g. correctional facilities, long-term care facilities, homeless shelters)?  
Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?  
Have you ever been a member of any of the following groups that may have 
an increased incidence of latent M. tuberculosis infection or active TB disease 
(e.g. medically underserved, low-income, drug/alcohol abusers)?

If you answered YES to any of the above questions, either a PPD test (Mantoux) OR Interferon Gamma Release Assay (IGRA) must be completed within 12 months prior to entering Allegheny College.

<table>
<thead>
<tr>
<th>PPD (Mantoux) Test:</th>
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<tbody>
<tr>
<td>Date Read:</td>
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<tr>
<td>Results (in mm of induration):</td>
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OR

<table>
<thead>
<tr>
<th>IGRA DATE:</th>
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<tbody>
<tr>
<td>Result (circle):</td>
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<tr>
<td>Positive</td>
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Chest X-ray required if PPD is positive (10mm or more), OR if IGRA is positive

Date Performed:  
Results (circle): Normal Abnormal (send report)

If you have had a positive PPD in the past, irrespective of BCG history, and not been treated, Chest X-ray is required. Document Above.

If you have been treated for a positive PPD, no further testing required. Document below.

Treatment for positive PPD? YES Describe: 

Signature of Health Care Provider (required)  Date

Printed Name of Health Care Provider (required)
Countries with High Incidence of Tuberculosis (TB)
(“High Incidence” is defined as areas with reported or estimated incidence of ≥ 20 cases/100,000 population)

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darassalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d’Ivoire
Democratic People’s Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People’s Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe