NIPISSING UNIVERSITY

Tuberculosis (TB) Surveillance Letter*

Student Name: _____ Student Number: _____

As the student's primary health care provider, I _____
Please Print Name

have deemed this student, whose Tuberculosis skin test is 'positive' (10mm or greater) to be absent of TB symptoms and at a (please check off appropriate box):

☐ low risk for active TB.

☐ moderate or high risk for active TB.

Note: if indicated as moderate or high risk for active TB, a new chest x-ray is required.

(Symptoms may include coughing that lasts longer than 2 weeks with green, yellow, or bloody sputum; weight loss, fatigue, fever, night sweats, chills, chest pain, shortness of breath and loss of appetite.)

Chest x-ray results required as per instructions from the Communicable Disease Screening Form (must attach copy of results if not previously submitted):

_____ _____
Result Date

_____ _____
Physician/Nurse Practitioner Signature & Designation Date

*Required for students with a current or past positive TB skin test result