TB SYMPTOM ASSESSMENT TOOL

Name (Last, First, MI)	Birthday *(mm/dd/yyyy)*	
Street Address	Telephone Number	
City	State	Zip Code
Date of TB Symptom Assessment *(mm/dd/yyyy):*		
Symptoms Suggestive of TB *(Check all that apply)*: ☐ Productive cough of undiagnosed cause (more than 3 weeks in duration) ☐ Coughing up blood (hemoptysis) ☐ Unexplained weight loss (10 pounds or greater without dieting) ☐ Night sweats (regardless of room temperature) ☐ Unexplained loss of appetite ☐ Very easily tired (fatigability) ☐ Fever ☐ Chills ☐ Chest pain **If any symptoms are reported a chest radiograph is an essential criterion for school admission.**		
☐ **No Symptoms Suggestive of TB Reported or Observed**		
Name of Licensed MD/RN *(Print)*		
Signature of Licensed MD/RN		Date

Adapted from the NJ Department of Health and Senior Services

Form available at: http://globaltb.njms.rutgers.edu/educationalmaterials/productfolder/tbhandbook.html