SCHOOL OF TECHNOLOGY & STUDENT SERVICES
Health Services Center
Phone: (671) 735-5586/5644/8889 Fax: (671) 734-8330

GCC TUBERCULOSIS SCREENING FORM

Name: ____ DOB: ____________________
(Last) (First) (Middle) (Month/Day/Year)

GCC ID: ____ Work Location: ______________________________

Please check one that applies to you. ( ) Employee ( ) Student

Rationale:
For Employees: Section 25103, Title 10 of the Guam Code Annotated requires that all individuals working in a public or private educational institution submit annually a copy of the TB test result and be declared free of communicable disease. *(Form has been revised to reflect updated LTBI Questionnaire from DPHSS, which has been updated by DPHSS on September 10, 2015.)*

For Students: Public Law 22-130 mandates all students to provide the school official a copy of the TB test result. The law also requires that a student with a positive test result obtain a Certificate of Tuberculosis Evaluation from the Department of Public Health & Social Services (DPHSS). *(Form has been revised to reflect updated LTBI Questionnaire from DPHSS, which has been updated by DPHSS on September 10, 2015.)*

Location: Mangilao DPHSS, 1st Floor, Rm. 118

Direction: Thoroughly read the following items and do what is indicated by them. You may be required to proceed to the next item. Items shown below must be completed by a physician, physician's assistant (PA), nurse practitioner (NP), or nurse; refer to each item for specifics.

1. Start with item 2 if you never had a TB test before; or the previous result was negative. If you have had a history of positive TB test, you do not need to have another TB test administered. You may proceed to item 4.

2. The TB skin test can be administered by a School Health Counselor at the Health Services Center. If a student is a minor, a parent or a guardian has to accompany the student or a parental consent has to be provided in writing. You will be instructed to return to the Health Center within 48-72 hours for the reading. If more than 72 hours have elapsed and you failed to have the test read, the test must be repeated and you may be charged twice on the health fee.

3. Have the School Health Counselor complete item 3 after skin test reading. If the skin test result is negative, you should be done once item 3 is completed. If your skin test result is positive, after item 3 you should proceed to item 4. Have a health care provider complete item 4.

The repeat of a TB skin test, if a client fails to show up for a scheduled reading, and the interpretation of TB skin test reading will be based on the protocol established by TB section of DPHSS.

Public Law 22-130 requires that any individual entering from an area other than the U.S. states or territories must have the test conducted within 6 months prior to enrollment.

Has the client been a resident of the U.S. or any of its territories within 6 months prior to this TB test administration?

Yes _______ No _______ If no, where did you reside? ____

Date Administered: _______________________________ Date Read: _____________________________ Result: _________________________ mm.

____
Name of Physician/PA/NP/Nurse (Print) Signature of Physician/PA/NP/Nurse Date Official Stamp

Revised February 2016/ELM / New Logo Update 3/7/17 ELM

4. If patient has not had a chest X-ray, the health provider may need to order one. Have the following competed by a MD, PA, or NP, and attach an official radiology report.

   a. Date of CXR Exam: _______________________ (Copy of report **MUST** be attached):

   b. □ Normal □ Abnormal Comments: ____

   c. LTBI Treatment
      - Date treatment started: _______________________ Date completed: _______________________ □ No h/o treatment
      - Adverse reactions to LTBI therapy? □ Yes □ No
      - Patient declined therapy? □ Yes □ No

   d. Have you been exposed to active TB? □ Yes □ No

   e. Does the person have any of the following symptoms:
      - Cough □ Yes □ No
      - Fever □ Yes □ No
      - Weight loss □ Yes □ No
      - Night Sweats □ Yes □ No
      - Fatigue □ Yes □ No
      - Chest Pain □ Yes □ No
      - Shortness of breath □ Yes □ No
      - Hoarseness □ Yes □ No

   If response is "yes" to any of the symptoms, patient will need a repeat 2 view CXR before referral to Public Health for clearance.

   Please include findings from repeat CXR (Copy of report **MUST** be attached):
   □ Normal □ Abnormal

   f. Patient is cleared for work/school: □ Yes □ No

   g. Patient is referred to the Department of Public Health Communicable Disease Clinic for possible active tuberculosis. **(All required documents MUST accompany referral.)**: □ Yes □ No

____

Name of Physician/PA/NP (Print) Signature of Physician/PA/NP Date Official Stamp

5. If you had the skin test done at a private health care provider and the reading is negative, proceed to the GCC Health Center and submit the skin test result.

6. If the result of the skin test is positive, submit the Certificate of Tuberculosis Evaluation Form to the GCC Health Center for clearance.

Checklist for GCC Health Center:

_______________________ Date this form to indicate when the required documentation was received.

Cleared by the School Health Counselor:

____

Full Name of Clearing Person Full Signature of Clearing Person Date