Cardiorespiratory Care
University of South Alabama
Immunizations and TB Status

Name: _____ Date: _____

Status of Records, Insurance and Immunizations
Clearance for entry into clinical courses

_____ Complete

_____ Drug Screen completed

_____ Proof of varicella immunization/disease

_____ MMR

_____ Background check completed

_____ Proof of medical insurance

_____ Immunization record on file

_____ Td/T dap

	1st	2nd (one month after 1st shot)	3rd(5 months after 2nd shot)
Hepatitis B			

	Fall - JR	Fall - SR
Influenza shot		

TB skin test done			
If TB is positive - CXR done and in the file			

As a result of this review- your status of participation in clinical classes is listed below.

1. Cleared for entry into Fall/Spring semester Junior year _____ (Yes / No)

2. Cleared for entry into Summer semester Senior year _____ (Yes / No)

3. Cleared for entry into Fall/Spring semester Senior year _____ (Yes / No)

_____
Director of Clinical Education

Cardiorespiratory Care
University of South Alabama
Tuberculosis Symptom Questionnaire

NAME:_____ DOB:_____ DATE: _____

Documented test history: Date of test:_____ Results:_____ mm

If recent positive test:
Chest X-ray date:_____ Results_____
_____

History of treatment for active TB disease or treatment for latent Tuberculosis Treatment (LTBI)? Yes_____ No_____
If Yes, When?_____ Where?_____
Number of months taken:_____
Was medication given by directly observed therapy? Yes_____ No _____
Medication(s) Taken:_____

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SYMPTOM ASSESSMENT DATE OF ASSESSMENT:_____

Do you currently have a productive cough? Yes_____ No_____
If yes, how long have you had it? _____Days _____Weeks _____Months
If yes, What color is the mucus?_____
If yes, are you coughing up blood? _____

Do you have "night sweats"? Yes _____ No _____
Do you have a low-grade fever? Yes _____ No _____

Have you had weight loss without dieting? Yes _____ No _____
If yes, how many pounds have you lost? _____

Have you had unusual tiredness or fatigue? Yes _____ No _____
If yes, how long? _____Days _____Weeks _____Months

Do you have chest pain? Yes _____ No _____
If yes, how long? _____Days _____Weeks _____Months

Do you have shortness of breath? Yes _____ No _____
If yes, how long? _____Days _____Weeks _____Months

Do you know someone who has or has had these symptoms? Yes _____ No _____
Comments/Referrals:
_____
_____
_____

Interviewer's Signature/Title: _____ Date _____