

St. Mary's College of Maryland
Student Health Services
Latent Tuberculosis Infection Screening for Adults AY 26/27
 Fall admission due: August 1 Spring admission due: January 1

Legal Name: _____ **Preferred Name** _____ **Pronouns** _____

Date of Birth: ___/___/___ **Biologic Sex Assigned at Birth** _____ **Student ID:** _____

Student, please complete the following questions:

1. Have you ever had close contact with people who are known or suspected of having active Tuberculosis (TB) disease? Yes No
2. Were you born in a country or territory listed below? (If yes, circle in table.) Yes No
3. Have you resided in or traveled to one or more of the countries or territories listed below for a combined total of 1 month or more? (If yes, circle in table.) Yes No
4. Have you been a resident, volunteer, or employee in high-risk congregate settings (e.g., correctional facilities, long-term care facilities, homeless shelters)? Yes No
5. Have you been a volunteer or health care worker serving clients at increased risk for active TB disease? Yes No
6. Have you been part of any group with increased risk of TB infection or disease (e.g., medically underserved, low-income, or substance use)? Yes No

Afghanistan	Cabo Verde	Dominican Republic	Guyana	Lao People's Democratic Republic	Moldova (Republic of)	Peru	Tuvalu
Algeria	Cambodia	Ecuador	Haiti	Lesotho	Mongolia	Philippines	Uganda
Angola	Cameroon	El Salvador	Honduras	Liberia	Morocco	Qatar	Ukraine
Anguilla	Central African Republic	Equatorial Guinea	India	Libya	Mozambique	Romania	Uruguay
Argentina	Chad	Eritrea	Indonesia	Lithuania	Myanmar	Russian Federation	Uzbekistan
Armenia	China	Eswatini	Iraq	Madagascar	Namibia	Rwanda	Vanuatu
Azerbaijan	China, <i>Hong Kong SAR</i>	Ethiopia	Kazakhstan	Malawi	Nauru	São Tomé & Príncipe	Venezuela (Bolivarian Republic of)
Bangladesh	China, <i>Macao SAR</i>	Fiji	Kenya	Malaysia	Nepal	Senegal	
Belarus	Colombia	Gabon	Kiribati	Maldives	Nicaragua	Sierra Leone	Viet Nam
Belize	Comoros	Gambia	Korea	Mali	Niger	Singapore	Yemen
Benin	Congo	Georgia	(Democratic Republic of)	Marshall Islands	Nigeria	Solomon Islands	Zambia
Bhutan	Congo (Democratic Republic of)	Ghana	(Democratic Republic of)	Mauritania	Niue	Somalia	Zimbabwe
Bolivia (Plurinational State of)	Côte d'Ivoire	Greenland	(Democratic Republic of)	Mexico	Northern Mariana Islands	South Africa	
Bosnia & Herzegovina	Djibouti	Guam	(Republic of)	Micronesia (Federal States of)	Pakistan	Sri Lanka	
Botswana		Guatemala	Kyrgyzstan	(Federal States of)	Palau	Sudan	
Brazil		Guinea-Bissau		Tajikistan	Panama	Suriname	
Brunei				Tanzania (United Republic of)	Papua New Guinea	Timor-Leste	
Darussalam				Thailand	Paraguay	Togo	
Burkina Faso						Tunisia	
Burundi						Turkmenistan	

If you answered **NO** to all questions, no further testing or action is required unless the healthcare provider identifies additional risk factors. In that case, the provider must complete and validate page 2.

If you answered **YES** to any question, or if additional risk factors are identified, the healthcare provider must complete the clinical evaluation and testing on page 2 and validate it.

TO BE COMPLETED BY A HEALTHCARE PROVIDER

Tuberculosis Skin Test (TST)	Date of test: ____/____/____	Results:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
OR				
Interferon Gamma Release Assay (IGRA): (QuantIFERON-TB Gold Plus (QFT-Plus) OR T-Spot TB)				
Date of test: ____/____/____		Results:	<input type="checkbox"/> Negative	<input type="checkbox"/> Positive
Chest X-ray: (required if current or previous TST or IGRA test is positive)				
Date of test: ____/____/____		Results:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
Bacteriologic examinations of sputum specimens, if indicated:				
Date of test(s):		Results:	_____	

*TB blood tests (and TB skin tests) should not be performed on people who have written documentation of a previous positive TB test result (TB blood test or TB skin test) or treatment for TB disease. Most people who have a positive TB test result will continue to have a positive test result. Additional TB blood tests will probably not contribute to medical care, regardless of the result.				

Print Provider Name: _____ **Phone:** _____

Address: _____

I have verified that this information is accurate to the best of my knowledge.

Provider Signature: _____ **Date:** _____



This screening tool is informed by:
American College Health Association. (April 2025). *Guidelines: Tuberculosis Risk Assessment and Management*.
[www.acha.org/wp-content/uploads/ACHA Tuberculosis Risk Assessment and Management April 2025.pdf](http://www.acha.org/wp-content/uploads/ACHA_Tuberculosis_Risk_Assessment_and_Management_April_2025.pdf)