

**Tuberculosis (TB) Surveillance Letter\***

Student Name: \_\_\_\_\_

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.

*(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):

Date: \_\_\_\_\_ Result \_\_\_\_\_

\_\_\_\_\_  
Physician/Nurse Practitioner/Registered Nurse's Signature

\_\_\_\_\_  
Date

\*Required for students with a positive TB skin test result