

New Jersey Department of Health

Symptom Assessment for Pulmonary Tuberculosis (TB) Religious Exemption – School TB Testing

Name (<i>Last, First, MI</i>)		Birthdate (<i>mm/dd/yyyy</i>)
Street Address		Telephone Number
City	State	Zip Code
Date of Symptom Assessment (<i>mm/dd/yyyy</i>)		
<p>TB-Like Symptoms (<i>Check all that apply</i>):</p> <p><input type="checkbox"/> Productive Cough of Undiagnosed Cause (more than 3 weeks in duration)</p> <p><input type="checkbox"/> Coughing Up Blood (Hemoptysis)</p> <p><input type="checkbox"/> Unexplained Weight Loss (10 pounds or greater without dieting)</p> <p><input type="checkbox"/> Night Sweats (regardless of room temperature)</p> <p><input type="checkbox"/> Unexplained Loss of Appetite</p> <p><input type="checkbox"/> Very Easily Tired (Fatigability)</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Chest Pain</p> <p>If any symptoms are reported a chest radiograph is an essential criterion for school admission.</p>		
<p><input type="checkbox"/> No TB-Like Symptoms Reported or Observed</p>		
Name of Licensed MD/RN (<i>Print</i>)		
Signature of Licensed MD/RN		Date