WISCONSIN LUTHERAN COLLEGE

HEALTH SERVICES

International Travel Re-Entry Form

NAME: _____ DOB: _____

1. I was born the following country: _____
2. I recently visited a the following county/countries: _____
3. The dates of my travel: _____
4. In the visited country, did you work or visit a nursing home, prison, or other residential institution? Yes No
5. Did you have any contact with a person known to have active TB? Yes No
6. Did you have any contact with a person known to have COVID-19? Yes No
7. Do you have any chronic medical conditions? Yes No
    a. If yes, please list: _____
8. Have you ever been treated for TB in the past? Yes No
9. Have you ever received the BCG vaccine? Yes No Unsure
10. Do you have any of the following?

☐ cough
☐ fever
☐ coughing up blood
☐ productive cough
☐ night sweats
☐ loss of appetite
☐ vomiting / diarrhea
☐ respiratory difficulty (shortness of breath)
☐ fatigue
☐ weight loss
☐ chest pain
☐ chills
☐ weakness
☐ other _____

☐ none of the above

I have personally completed this form.

Signature: _____ Date: _____

Updated: 3/12/2020