UCDAVIS
STUDENT HEALTH AND COUNSELING SERVICES

Tuberculosis (TB) Health Assessment Form

Name of Student: ____

SID#: ____________________________________ Date of Birth: __________________

This student is **REQUIRED to complete tuberculosis testing** prior to enrolling in classes.
The form must be **completed and signed by a licensed health care provider**. All indicated test results **MUST** be in English.

I certify the student is free of infectious tuberculosis.

____ ________________________
Signature of Licensed Healthcare Provider **Date**

____
NPI or Medical License Number

____
Printed Name of Licensed Healthcare Provider **MD/NP/PA/RN**

Office Stamp

TESTING

All testing must be done within 12 months prior to the first day of class. Anticipated first day of class: __________

1. Tuberculosis Test
   Choose one of the following options:

   a. Tuberculin Skin Test (TST) Date placed: _____________ Date read: _____________
      Results: _____________ mm induration. (If no induration, write 0)
      Interpretation: _____ Negative _____ Positive (if positive, proceed to #2)

   b. TB Blood Test (Interferon Gamma Release Assay - IGRA - T-Spot-Quantiferon) recommended if history of BCG vaccine.
      Date Obtained: _____________
      Result: _____ Negative _____ Positive (if Positive, proceed to #2)
      _____ Indeterminate (If Indeterminate, repeat test or proceed to #3)

2. Chest X-ray (**REQUIRED** if TST or IGRA is positive) Must attach written radiology report (do not send film/CD):

   Date of chest x-ray: _________________ Result: _________________

3. Treatment: *(if applicable)*
   Medication(s): ____
   Date Completed: ____
   If regiment not completed, please indicate reason:
   ____
   ____
   ____

Questions? visit www.shcs.ucdavis.edu