UCDAVIS
STUDENT HEALTH AND COUNSELING SERVICES

Name of Student ____________________

Date of Birth (month/day/year) ____________________

SID# ____________________

Tuberculosis (TB) Health Assessment Form

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.

History Questions (ALL QUESTIONS MUST BE ANSWERED)	Yes	No	Comments
Does the student have signs/symptons of active TB disease? (Cough greater than 3 weeks, hemoptysis, unexplained weight loss or fever, night sweats)			
Has the student ever been treated for latent tuberculosis infection? Medications ________ Start date ________ End date ________			
Has the student ever been treated for active TB disease? (*If yes, must attach summary of treatment letter)*			

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. TB Blood Test (Interferon Gamma Release Assay - IGRA - T-Spot-Quantiferon)
recommended if history of BCG vaccine; if not available, may do a TST or chest x-ray
Date Obtained: ____________

Result: ☐ Negative ☐ Positive **(If Positive, proceed to #2 - Chest x-ray)**
☐ Indeterminate **(If Indeterminate, repeat test or proceed to #3)**

b. Tuberculin Skin Test (TST)
≥ 5mm is positive if:

- Recent close contact with someone with active infectious TB disease
- Immunosuppressed (splenectomy, HIV, chemotherapy, transplant patient)
- History of an abnormal chest x-ray suggestive of TB

Otherwise ≥ 10mm is positive

Date placed: ____________ Date read: ____________

Results: ________ mm induration. (If no induration, write ⦸)

Interpretation: ☐ Negative ☐ Positive(If Positive, proceed to #2 - Chest x-ray)

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:
☐ Normal
☐ Abnormal - r/o active TB must have Sputum Induction - proceed to #3
☐ Abnormal -other- Specify: ____________________

3. Sputum Results (AFB smear and cultures x 3 are **required** if the chest x-ray is read as concerning for TB)

#1 Date ____________ AFB ____________ Culture ____________

#2 Date ____________ AFB ____________ Culture ____________

#3 Date ____________ AFB ____________ Culture ____________

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

OFFICE STAMP

FOR QUESTIONS GO TO WWW.SHCS.UCDAVIS.EDU