UCI Student Health Center

Name of Student _____

Date of Birth *(month/day/year)* _____

Student ID# _____

TUBERCULOSIS (TB) HEALTH ASSESSMENT FORM

Your answers to questions on the Tuberculosis Risk Screening Questionnaire indicate that you either have A (immune suppressed condition that places you at higher risk) or B (Previous (+) TST/IGRA). Because of this, you need to have this form completed & signed by a LICENSED HEALTH CARE PROVIDER.

A. IMMUNOSUPPRESSED MEDICAL CLEARANCE FORM (HIV infection, organ transplant recipient with TNF-alpha antagonist, steroids, immunosuppressive medicines)

TB BLOOD TEST: Check one: ☐IGRA QUANTIFERON ☐ IGRA T-Spot (within 12 months of date of 1st attendance at UCI)

Date Obtained: _____ Result: ☐ Negative ☐ Positive (need Chest X-ray) ☐ Indeterminate (need Chest X-ray)

Please attach test results. Test results must be translated into ENGLISH.

B. PREVIOUS POSITIVE TB TEST MEDICAL CLEARANCE FORM

1. TUBERCULIN SKIN TEST (TST/PPD)	**OR**	**TB BLOOD TEST**
Date placed: _____ Date read: _____ Result: _____ mm induration Interpretation: ☐ Negative ☐ Positive (need Chest X-ray)		Check one: ☐ IGRA QUANTIFERON or ☐ IGRA T Spot Date Obtained: _____ Result: ☐ Negative ☐ Positive (need Chest X-ray) ☐ Indeterminate (need Chest X-ray)

2. CHEST X-RAY (within 12 months of date of 1st attendance at UCI if TB Skin Test or IGRA blood test is positive)

Date of Chest x-ray: _____ Result: ☐ Normal ☐ Abnormal

Please attach test results. Test results must be translated into ENGLISH.

3. SYMPTOM REVIEW: CHECK ALL THAT APPLY

Does Patient currently have any of the following symptoms?:

☐Cough greater than 4 weeks ☐Coughing up blood (Hemoptysis) ☐ NONE

☐Unexplained weight loss ☐Persistent fevers/chills or night sweats

☐Unexplained chest pain ☐Persistent, unexplained fatigue

4. TREATMENT — CHECK ONE

☐Treatment for TB was explained to the patient and treatment was declined

or

☐Treatment History: Name of medication(s) _____

Start Date _____ Duration of therapy _____

I certify the student is free of infectious tuberculosis.

_____ _____ _____

Printed Name & Signature of Healthcare Provider (MD/DO/PA/NP) License# State or Country

_____ _____ _____

Office Address Telephone Date

See our FAQ Page at https://shc.uci.edu/new-student-information/immunization-requirements