Tuberculosis (TB) Health Assessment Form  
UCI Student Health Center

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** and indicated test results attached.

<table>
<thead>
<tr>
<th>History Questions (ALL QUESTIONS MUST BE ANSWERED)</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the student have signs/symptoms of active TB disease? (Cough greater than 3 weeks, hemoptysis, unexplained weight loss or fevers, night sweats)</td>
<td></td>
<td></td>
<td>If yes, evaluate as clinically appropriate.</td>
</tr>
<tr>
<td>Has the student ever been treated for latent tuberculosis infection? Medication_______________ Start date_____________ End date ____________</td>
<td></td>
<td></td>
<td>If yes, please attach documentation if available. No further testing required at this time.</td>
</tr>
<tr>
<td>Has the student ever been treated for active TB disease?</td>
<td></td>
<td></td>
<td>If yes, must attach summary of treatment letter and most recent chest x-ray report. No further testing required at this time.</td>
</tr>
</tbody>
</table>

**TESTING** – All testing must be done within 12 months prior to enrollment.

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)
      □ Indeterminate (If Indeterminate, repeat test or proceed to #2)
   b. **Tuberculin Skin Test (TST)**  
      ≥5 mm 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:_____________
      Result: _______ mm induration. (If no induration, write Ø)
      Interpretation: □ Negative □ Positive (If Positive, Proceed to #2)

2. **Chest X-ray (REQUIRED if TST or IGRA is positive)** *Must attach written radiology report*
   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  
__________________________  
Printed Name of Licensed Healthcare Provider  
__________________________  
Date  
Office Stamp

For questions, see our FAQ Page at [https://shc.uci.edu/new-student-information/immunization-requirements](https://shc.uci.edu/new-student-information/immunization-requirements)  
or send an email to: shc-immunization@uci.edu