**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 healthcare provider.** All indicated test results **MUST** be in English.

### History Questions (ALL QUESTIONS MUST BE ANSWERED)

<table>
<thead>
<tr>
<th>Question</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?</td>
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<td>(Cough greater than 3 weeks, hemoptysis, unexplained weight loss or fever, night sweats)</td>
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<td>Has the student ever been treated for latent tuberculosis infection?</td>
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<tr>
<td>Medications Start date End date</td>
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<tr>
<td>Has the student ever been treated for active TB disease?</td>
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<td><em>(If yes, must attach summary of treatment letter)</em></td>
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### 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**

**FOR QUESTIONS GO TO WWW.SHCS.UCDAVIS.EDU**