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.

Office Stamp

_____ _____
Signature of Licensed Healthcare Provider **Date**

_____
NPI or Medical License Number

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

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; 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 #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