UCDAVIS
STUDENT HEALTH AND COUNSELING SERVICES

UNIVERSITY OF CALIFORNIA DAVIS TUBERCULOSIS (TB) SCREENING FORM

The health of the individual can affect the health of the campus community. UC Davis is committed to protecting the health and well-being of all our students. To protect the campus from communicable diseases, screenings are part of the admission process for all new and re-admitted students prior to arrival to UC Davis.

The results of your Tuberculosis (TB) Risk Screening indicate you are at higher risk of TB. Because of this, you are **REQUIRED TO SUBMIT FURTHER DOCUMENTATION** to avoid a hold on your registration for classes. This form must be completed and signed by a **LICENSED physician, nurse practitioner, or physician's assistant** (DO, MD, NP, or PA).

Please read this entire instruction page and follow the instructions below.

1. Print ALL pages of the form.
2. Visit your health care provider to complete the form and perform all required testing. They must completely fill out the form.
3. Page 2 is not required UNLESS you have tested positive for TB in the past, OR, newly test positive for TB.
4. Upload your completed form to Health e-Message (HeM) portal at: https://hem.ucdavis.edu by logging on and then going to **Medical Clearances -- TB Health Screening Form**
    - After uploading the completed form, please **allow up to 21 days** for review of your form. Once a nurse has reviewed your form you will see "TB Form Reviewed" as Compliant with a green check mark.
    - We will send you a secure message through the HeM portal if we have questions or need additional information before you can be cleared. Please monitor the email address you have given UC Davis.
5. **Incomplete forms will not meet the requirement. Ensure all required fields are completed and your personal information (name, date of birth) is on the form and it is signed before submitting. Submitting a blank or incomplete form can cause a registration hold and delays.**

Please see our website at https://shcs.ucdavis.edu/new-students regarding this process. If you still have questions go to HeM at https://hem.ucdavis.edu, go to Messages and write to the Immunization Nurse box.

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UCDAVIS
STUDENT HEALTH AND COUNSELING SERVICES

UC DAVIS TUBERCULOSIS (TB) SCREENING MEDICAL CLEARANCE FORM

Name _____ Date of Birth (MM/DD/YYYY) _____ Student ID # _____

A licensed healthcare provider is required to complete this form prior to enrolling in classes.

All sections of this page must be completed and signed by a LICENSED HEALTH CARE PROVIDER AND must be received by UC Davis Student Health NO LATER than your first day on campus.

All TB testing must be completed within the 12 months prior to first date of attendance at UC Davis. If it is older than 12 months, it does not satisfy the requirement. A chest x-ray without a history of a positive TB test is NOT sufficient for clearance.

0. History of BCG Vaccination? Yes ☐ No ☐

1. TB Symptom and Risk Review

Does the patient have any of the following symptoms? Please check any and all that apply.

☐ Cough lasting 3 weeks or longer ☐ Chest pain ☐ Coughing up blood or sputum

☐ Unexplained weakness or fatigue ☐ Unexplained weight loss ☐ Unexplained loss of appetite

☐ Fever ☐ Chills ☐ Night sweats

☐ NONE OF THE ABOVE

Is the patient immunosuppressed, current or planned? Yes ☐ No ☐

Is the patient living with HIV/AIDS, an organ transplant recipient, or taking medications that suppress the immune system?

Yes ☐ No ☐

IF any YES, please explain: _____

2. TB Testing

IGRA TB Blood Test (*Preferred*)

Date of Test: _____

Test Performed (check one)

☐ QuantiFERON TB Gold Plus ☐ T-Spot TB

Test Result (check one)

☐ Negative ☐ Positive* ☐ Indeterminate*

OR

Tuberculin Skin Test (TST/PPD)

Date placed: _____ Date read: _____

Result: _____ mm induration

TST/PPD of 10mm or greater is considered positive regardless of history of BCG and/or a negative TB blood test result. Refer to CDC PPD guidelines if needed: https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html

Interpretation: ☐ Negative ☐ Positive*

***If result is positive or weakly positive, must also complete "Positive Tuberculosis Test Clearance" section (see other side)**

3. Attestation and Signature

I certify that the named student is free of infectious tuberculosis. _____

Licensed Health Care Provider Signature

Printed Name of Licensed Health Care Provider _____ NPI or License Number _____ Date _____

( ) _____

Provider Phone Number _____ Provider Street Address _____

City _____ State _____ Country, if not USA _____

UC DAVIS
STUDENT HEALTH AND COUNSELING SERVICES

UC DAVIS PREVIOUS POSITIVE TUBERCULOSIS (TB) MEDICAL CLEARANCE FORM

ONLY complete this form if patient has current or past POSITIVE/WEAK POSITIVE TB test

Name _____ Date of Birth (MM/DD/YYYY) _____ Student ID # _____

All sections of this page must be completed and signed by a LICENSED HEALTH CARE PROVIDER AND must be received by UC Davis Student Health NO LATER than your first day on campus. A chest x-ray without a history of a positive TB test is NOT sufficient for clearance.

1. Previous Positive TB Test Information

IGRA TB Blood Test (*Preferred*)

Date of Test: _____

Test Performed (check one)

☐ QuantiFERON TB Gold Plus ☐ T-Spot TB

Test Result (check one)

☐ Negative ☐ Positive ☐ Indeterminate

OR

Tuberculin Skin Test (TST/PPD)

Date placed: _____ Date read: _____

Result: _____ mm induration

TST/PPD of 10mm or greater is considered positive regardless of history of BCG and/or a negative TB blood test result. Refer to CDC PPD guidelines if needed: https://www.cdc.gov/tb/hcp/testing-diagnosis/tuberculin-skin-test.html

Interpretation: ☐ Negative ☐ Positive*

2. TB Symptom and Risk Review

Does the patient have any of the following symptoms? Please check any and all that apply.

☐ Cough lasting 3 weeks or longer ☐ Chest pain ☐ Coughing up blood or sputum

☐ Unexplained weakness or fatigue ☐ Unexplained weight loss ☐ Unexplained loss of appetite

☐ Fever ☐ Chills ☐ Night sweats

☐ NONE OF THE ABOVE

Is the patient immunosuppressed, current or planned? Yes ☐ No ☐

Is the patient living with HIV/AIDS, an organ transplant recipient, or taking medications that suppress the immune system?

Yes ☐ No ☐

IF any YES, please explain: _____

3. Chest X-RAY (must be completed on or after date of positive TB test unless documentation for completed TB/LTBI treatment is included, e.g. Treatment Completion Letter)

All TB testing must be completed within the 12 months prior to first date of attendance at UC Davis. If chest x-ray is older than 12 months, it does not satisfy the requirement. A chest x-ray without a history of a positive tb test is not sufficient for clearance

Date of chest X-RAY: _____

Result: ☐ Normal ☐ Abnormal

4. Tuberculosis (TB) Treatment (if treatment has been completed, please include documentation, e.g. treatment completion letter)

☐ Patient DECLINED treatment, after treatment for TB was explained.

OR

☐ Patient was TREATED for TB/LTBI Start Date _____ Completion Date _____ Therapy Duration _____

Name/Dose of Medication(s) _____

If regimen was not completed, please indicate reason: _____

5. Attestation and Signature

I certify that the named student is free of infectious tuberculosis. _____

Licensed Health Care Provider Signature

Printed Name of Licensed Health Care Provider _____ NPI or License Number _____ Date _____

( ) _____

Provider Phone Number _____ Provider Street Address _____

City _____ State _____ Country, if not USA _____