TUBERCULOSIS (TB) HEALTH ASSESSMENT FORM UNIVERSITY OF CALIFORNIA, SANTA CRUZ

Name _____ Date of Birth _____ Student ID _____

A LICENSED PROVIDER IS REQUIRED TO COMPLETE THIS FORM PRIOR TO ENROLLING IN CLASSES. All four sections of this form must be **completed and signed by a LICENSED HEALTH CARE PROVIDER** and must be received by UCSC Student Health **NO LATER than the first day on campus**.

1. TUBERCULIN SKIN TEST (TST/PPD) ---- ---- OR ¢{¢ĸtt5 2Ŧmpaa 2ℕ ∃ℕŜI·úŜℕ ƛă Ŏ2yãƛŘŜℕŜŘ LJ2ăƛúƛØŜ **regardless** 2Ŧ Kƛăú2ℕè 2Ŧ . / D I·yŘĸ2ℕ I· yŜ∃I·úƛØŜ ¢ . ōf22Ř úŜăú ℕŜădztú	**1. TB BLOOD TEST**
Date placed:_____ **Date read**:_____ **Result**:_____ mm induration **Interpretation**: ☐ **Negative** ☐ **Positive**	QUANTIFERON / T Spot / Interferon Gamma Release Assay **Date Obtained**:_____ Result: ☐ **Negative** ☐ **Positive** ☐ **Indeterminate***
2. CHEST X-RAY	
Date of Chest x-ray:_____ (must be performed after positive TB test)	**Result:** ☐ Normal ☐ Abnormal
3. Symptom Review	
Does Patient currently have any of the following symptoms?: (please check any that apply) ☐ **Cough for greater than 4wks** ☐ **Coughing up blood** ☐ **Unexplained Chest pain/fevers/chills/night sweats** ☐ **Persistent fatigue** ☐ **Unexplained weight loss** ☐ **None**	
4. Treatment	
☐ **Treatment for TB was explained to the patient and they declined treatment.** **OR** **Treatment History:** **Name of medication(s)_____** **Start Date _____** **Duration of therapy _____**	

I certify the student is free of active TB disease.

Licensed Health Care Provider Name _____ Signature _____ Date _____

Provider contact information:
Phone:_____

Address:_____