Dear Student,

The health of the individual can affect the health of the campus community. UCSC is committed to protecting the health and well-being of all our students. In order 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 UCSC.

Your answers to the Tuberculosis (TB) screening questions indicate you have either:
A) Have an immune suppressed condition that places you at higher risk.
OR
B) Previously tested positive for tuberculosis

Because of this you are REQUIRED TO SUBMIT FURTHER DOCUMENTATION. Please read and follow the instructions below:

1. Read this entire instruction page.
2. Print the 2 page assessment form.
3. Visit your health care provider to complete the form and perform all required testing based on your Risk Factor A or B.
4. Upload your completed form to Health e-Messenger at https://studenthealth.ucsc.edu
Then Logon and go to messages and reply to the Immunization Provider
• CONFIRMATION OF RECEIPT OF YOUR DOCUMENT(S) IS NOT POSSIBLE.
• Clearance can take up to ten business days after receipt
• To verify your TB Compliance status go to Health e-Messenger (https://studenthealth.ucsc.edu) and select immunizations refer to Disease Compliance Status for "TB Medical Clearance" or "TB Test Pos"

Please see our website at http://healthcenter.ucsc.edu/information/uc_vaccines.html regarding this process. If you still have questions go to Health e-Messenger at https://studenthealth.ucsc.edu go to messages and reply to the Immunization Provider.

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A) UCSC IMMUNOSUPPRESSED TUBERCULOSIS TEST Medical Clearance Form

Name __________________________ Date of Birth ___________ Student ID # __________

A LICENSED 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 UCSC Student Health NO LATER than your first day on campus.

TB BLOOD TEST: Within the 2 months Prior to your first date of attendance at UCSC.

Circle one:
IGRA QUANTIFERON or IGRA T Spot

Date Obtained: __________________

Result: □ Negative □ Positive □ Indeterminate (* Positive or Indeterminate=proceed to Step 2, 3 and 4 on next page.)

I certify the above named student is free of active TB disease.

Licensed Health Care Provider Name __________________________ Signature __________________ Date __________________

Provider Phone: (_____)________________________

Provider Address __________________________________ City________________________ State _____ Zip Code__________

Country if not USA____________________________________

Please see Page 2 for “Previous Positive Tuberculosis Test” Medical Clearance Form

HC: 1075 (7/30/18)
B) UCSC PREVIOUS POSITIVE TUBERCULOSIS TEST Medical Clearance Form

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 1. TB BLOOD TEST
TST/PPD of 15MM or greater is considered positive regardless of history of BCG and/or a negative TB blood test result

Date placed: ___________ Date read: ___________
Result: _______ mm induration
Interpretation: □ Negative □ Positive

Circle one: IGRA QUANTIFERON or IGRA T Spot
Date Obtained: ___________
Result: □ Negative □ Positive □ Indeterminate*

2. CHEST X-RAY

Date of Chest x-ray: ___________ Result: □ Normal □ Abnormal
(must be performed after positive TB test)

3. Symptom Review—check all that apply

Does Patient currently have any of the following symptoms?: (please check any that apply)

☐ Cough for greater than 4wks ☐ Coughing up blood ☐ Persistent fatigue
☐ Unexplained weight loss ☐ Unexplained Chest pain/fevers/chills/night sweats
☐ NONE

4. Treatment—check one

☐ 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 above named student is free of active TB disease.

_________________________________________ ___________________________ ___________________________
Licensed Health Care Provider Name Signature Date

Provider Phone: (____)____________________
Provider Address __________________________ City __________________________ State ___ Zip Code ________
Country if not USA_________________________

HC: 1075 (7/30/18)