UNIVERSITY OF CALIFORNIA, SANTA CRUZ (UCSC)

TUBERCULOSIS SCREENING ADMISSION REQUIREMENT

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) Previously tested positive for tuberculosis
OR
B) Have an immune suppressed condition that places you at higher risk.
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

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