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 previously tested positive for tuberculosis and are **REQUIRED TO SUBMIT FURTHER DOCUMENTATION**.

Please read and follow the instructions below:

1. **Read** this entire instruction page.

2. **Print** the assessment form.

3. **Visit your health care provider** to complete the form and perform all required testing.

4. **Upload your completed form to Health e-Messenger** at https://studenthealth.ucsc.edu
   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.
TUBERCULOSIS (TB) MEDICAL CLEARANCE 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 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

<table>
<thead>
<tr>
<th>Date placed:</th>
<th>Date read:</th>
<th>Result:</th>
<th>Interpretation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>_____ mm induration</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Negative □ Positive</td>
<td></td>
</tr>
</tbody>
</table>

QUANTIFERON / T Spot / Interferon Gamma Release Assay

<table>
<thead>
<tr>
<th>Date Obtained:</th>
<th>Result:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Negative □ Positive □ Indeterminate*</td>
</tr>
</tbody>
</table>

2. CHEST X-RAY
Date of Chest x-ray: ____________ (must be performed after positive TB test)

<table>
<thead>
<tr>
<th>Result:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Normal □ Abnormal</td>
</tr>
</tbody>
</table>

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: __________________________

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