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 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**	QUANTIFERON / T Spot / Interferon Gamma Release Assay **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

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:_____