

**Tuberculosis (TB) Health Assessment Form**  
**University of California, Santa Barbara**

Name of Student \_\_\_\_\_

Date of Birth (month/day/year) \_\_\_\_\_

Perm# \_\_\_\_\_

This student is **REQUIRED to complete tuberculosis testing** prior to enrolling in classes.  
 The form must be **completed and signed by a licensed health care provider** and the test results attached.

History Questions (ALL 6 QUESTIONS MUST BE ANSWERED)	Yes	No	Comments
Has the student ever had a positive IGRA test (Quantiferon or T-Spot)?			If yes, order chest x-ray & symptom screen.
Has the student ever had a positive TB skin test?			If yes, order an IGRA.
Has the student ever been treated for latent tuberculosis infection? Medication _____ Start date _____ End date _____			If yes, please attach documentation if available. No further testing required at this time.
Has the student ever been treated for active TB disease?			If yes, must attach summary of treatment letter and most recent chest x-ray report. No further testing required at this time.
Has the student ever had close contact with persons known or suspected to have active TB disease?			Date of last contact: _____
Does the student have signs/symptoms of active TB disease? (Cough greater than 3 weeks, hemoptysis, unexplained weight loss, fevers, night sweats)			If yes, evaluate as clinically appropriate.

**TESTING – ALL TESTING MUST HAVE BEEN WITHIN ONE YEAR OF UCSB ENTRANCE**

**1. Tuberculosis Test**

Choose one (a. or b.) of the following options:

**a. TB Blood Test (IGRA)**

*Recommended if history of BCG vaccine; if not available, may do a TST or chest xray.*

Date Obtained: \_\_\_\_\_

- Result:  Negative  Positive (If Positive, proceed to #2)  
 Indeterminate (If Indeterminate, repeat test or proceed to #2)

**b. Tuberculin Skin Test (TST)**

**≥5 mm is positive if:**

- Recent close contact with someone with active infectious TB disease
- Immunosuppressed (splenectomy, HIV, chemotherapy, transplant patient)
- History of an abnormal chest x-ray suggestive of TB

**Otherwise ≥10mm is positive**

Date placed: \_\_\_\_\_ Date read: \_\_\_\_\_

Result: \_\_\_\_\_ mm induration. (If no induration, write ∅)

Interpretation:  Negative  Positive (If Positive, proceed to #2)

**2. Chest X-ray (REQUIRED in last 12 months if current or past TST or IGRA is positive) \*Must attach written radiology report**

Date of chest x-ray: \_\_\_\_\_

- Result:  Normal  
 Abnormal - r/o active TB must have Sputum Induction - proceed to #3  
 Abnormal - other – Specify: \_\_\_\_\_

**3. Sputum Results (3 negative AFB smears and cultures are required if the chest x-ray is read as concerning for TB)**

#1 Date \_\_\_\_\_ AFB \_\_\_\_\_ Culture \_\_\_\_\_

#2 Date \_\_\_\_\_ AFB \_\_\_\_\_ Culture \_\_\_\_\_

#3 Date \_\_\_\_\_ AFB \_\_\_\_\_ Culture \_\_\_\_\_

Submit this form by uploading it on Gateway: <https://studenthealthoc.sa.ucsb.edu>

or by emailing it to [SHSEntranceImmunizations@sa.ucsb.edu](mailto:SHSEntranceImmunizations@sa.ucsb.edu) or FAX (805) 893-3593

For questions, see our FAQ Page at [http://studenthealth.sa.ucsb.edu/medical-services/immunization-information/university-immunization-requirements/tuberculosis-\(tb\)-screening-requirement](http://studenthealth.sa.ucsb.edu/medical-services/immunization-information/university-immunization-requirements/tuberculosis-(tb)-screening-requirement) or Phone (805) 893-2525

**I certify the student is free of infectious tuberculosis.**

\_\_\_\_\_  
 Signature of Licensed Healthcare Provider

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Printed Name of Licensed Healthcare Provider

\_\_\_\_\_  
 MD/DO/NP/PA/RN

Office Stamp  
 or  
 Address & Phone