UCSB
STUDENT HEALTH
Compassion • Quality • Convenience

Name of Student _____

Date of Birth *(month/day/year)*_____

Perm# _____

Tuberculosis (TB) Health Assessment Form

This student has been **identified through initial screening** and is **REQUIRED** to complete one of the approved **tuberculosis tests** below 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 & order chest x-ray.
Has the student ever been treated for active TB disease?			If yes, must attach summary of treatment letter and chest x-ray within the last 12 months.
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 Ø)

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 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 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