UC RIVERSIDE UNIVERSITY OF CALIFORNIA | Student Health Services

TUBERCULOSIS (TB) MEDICAL CLEARANCE FORM
UNIVERSITY OF CALIFORNIA, RIVERSIDE

Name _____ Date of Birth _____ Student ID _____

This form must be **completed and signed by a LICENSED HEALTH CARE PROVIDER**

TESTING - ALL TESTING MUST HAVE BEEN DONE ON OR AFTER SEPTEMBER 25, 2016

1. Tuberculosis Test Choose ***one a or b***

a. Tuberculin Skin Test - (PPD)	b. TB blood test – (IGRA: QuantiFERON or T-SPOT)
➢ 10 mm is positive ➢ 5 mm is positive if: ·Close contact with TB infected person ·Immunosuppressed ·History of abnormal chest x-ray suggestive of TB	Preferred if history of BCG vaccine. If unavailable, TST or x-ray accepted.
Date placed _____ Date read _____ Result:_____ mm induration or Ø Interpretation: □Negative (Proceed to #4) □Positive (proceed to #2) Read by: _____	□QuantiFERON □T-SPOT Date of blood test: _____ Result: □Negative □Positive (Proceed to #2a) □Indeterminate (If Indeterminate, repeat or proceed to #2) *Must attach test result

2. Chest X-ray (REQUIRED in the last 12 months if current or past IGRA is positive) *Must attach x-ray report
   Date of chest x-ray:_____
   Result: □Normal □Abnormal -r/o active TB(Proceed to #3) □Abnormal –other specify: _____

3. Sputum results: (3 negative results are required)
   #1 Date _____ AFB_____ Culture_____
   #2 Date _____ AFB_____ Culture_____
   #3 Date _____ AFB_____ Culture_____

4. I certify the student named above is free of active TB disease.

_____ _____
Signature (Licensed Healthcare Provider) Date

_____ _____
Printed Name of (Licensed Healthcare Provider) Phone Number