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**)

- 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
- ≥ **15 mm** is considered positive in any person, including persons with no known risk factors for TB.

Date placed _____ Date read _____

Result:_____ mm induration or Ø

Interpretation:

□Negative (Proceed to #4) □Positive (proceed to #2)

Read by: _____

b. TB blood test – (**IGRA**: QuantiFERON or T-SPOT)

Required if history of BCG vaccine or past/present positive PPD.

□QuantiFERON □T-SPOT

Date of blood test: _____

Result: □Negative □Positive (Proceed to #2a)
□Indeterminate (If Indeterminate, repeat or proceed to #2a)
***Must attach test result**

2. IGRA blood test (QuantiFERON/T-SPOT)**:**

Date _____ **Result**: □Negative □Positive (Proceed to #3)
□Indeterminate (If Indeterminate, repeat or proceed to 2a)

a. 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)

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