UC RIVERSIDE UNIVERSITY OF CALIFORNIA | Student Health Services

Dear Student,

The health of the individual can affect the health of the campus community. UCR is committed to protecting the health and well-being of all our students. In order to protect the campus from communicable diseases, screenings are part of the admission process for all new and re-admitted students prior to arrival to UCR.

Your answers to the Tuberculosis (TB) screening questions indicate you have previously tested positive for tuberculosis and are REQUIRED TO SUBMIT FURTHER DOCUMENTATION.

Please read and follow the instructions below:

1. Read this entire instruction page.

2. Print the assessment form.

3. Visit your health care provider to complete the form and perform all required testing.

4. Tuberculosis Testing must have been performed within 1 year of entering the University.

5. Upload your completed and signed form in the patient portal at https:\\chconline.ucr.edu in the Student Immunization Records link.

UC RIVERSIDE UNIVERSITY OF CALIFORNIA | Student Health Services

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

_____ _____ _____
Name Date of Birth Student ID

All four sections of this form must be **completed and signed by a LICENSED HEALTH CARE PROVIDER**

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:_____ (must be performed after positive TB test) **Result:** ☐ Normal ☐ Abnormal	
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 Signature Date

Provider contact information: _____