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 COMPLETED WITHIN 12 MONTHS OF SUBMISSION

1. Tuberculosis Test Choose ***one a or b (Choose B if previous history of BCG)***

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

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)

Preferred if history of BCG vaccine.
If unavailable, TST or x-ray accepted.

□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. TB Treatment History:

Medication(s):_____

Start Date:_____

Duration of therapy:_____

OR:

□Treatment was explained and the above named patient declined_____

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