Tuberculosis (TB) Medical Clearance Form
University of California, Merced

To be completed by licensed healthcare provider

Name: _____

Date of Birth: _____

Student ID: _____

A) Symptom Review and Health History

Yes	No	
		Does student have signs/symptoms of active TB disease (e.g. cough greater than 3 weeks, hemoptysis, unexplained weight loss or fevers, night sweats, etc.)? *If yes, evaluate as clinically appropriate.*
		Has student ever been treated for latent tuberculosis infection? *If yes, documentation of treatment must be attached. No further testing required at this time. If no documentation is available, proceed to Box #2 under Diagnostic Testing below.* Medication: Start Date: End Date:
		Has student ever been treated for active TB disease? *If yes, must attach summary of treatment letter and most recent chest x-ray report. No further testing required at this time. If no documentation is available, proceed to Box #2 under Diagnostic Testing below.*

B) Diagnostic Testing

All testing must be done within 12 months prior to enrollment.

#1 TUBERCULOSIS TEST: Choose one of the following testing methods. *Skip if student has already had positive TB test in the past*

TB Blood Test (IGRA/T-spot/Quantiferon)
Recommended if history of BCG vaccine; if not available, may do a TST or chest x-ray

Date Obtained: _____

□ Negative
□ Positive (proceed to #2)
□ Indeterminate (repeat test or proceed to #2)

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, ≥10 mm is positive

Date Placed: _____ Date Read: _____

Result: _____ mm in duration (if none, write Ø)

□ Negative
□ Positive (proceed to #2)

#2 CHEST X-RAY: *Required if TST or IGRA is positive or if patient had treatment of TB in the past but no documentation available. Must attach written radiology report (not film/CD) completed within past 12 months*

Date of Chest X-ray: _____

□ Normal

□ Abnormal – r/o active TB (proceed to #3)

□ Abnormal – other

Specify: _____

#3 SPUTUM RESULTS: *AFB smear and cultures x3 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 _____

C) Certification of Clearance

I certify the student is free of infectious tuberculosis

_____ _____
Signature of Licensed Healthcare Provider Date

_____ _____
Printed Name of Healthcare Provider MD/NP/PA/RN

Office Stamp