UC San Diego
International Students & Programs Office

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FORM C: TUBERCULOSIS (TB) QUESTIONNAIRE AND RISK ASSESSMENT

NOTE: Required for students attending UC San Diego Summer Session. The form must be completed and signed by a Licensed Health Care Provider.

PART 1: STUDENT INFORMATION

NAME OF STUDENT: _____
(Family/Last Name) *(First/Give Name)* *(Middle Name)*

DATE OF BIRTH: _____ STUDENT PID #: _____
(MM/DD/YYYY)

PART 2: TB QUESTIONNAIRE

NOTE: Student please answer the following questions:

1. Have you previously tested positive for TB? ☐ **YES** ☐ **NO**
2. Have you had close contact to someone with infections TB at any time? ☐ **YES** ☐ **NO**
3. Were you born outside of the United States, Canada, Australasia or Western/Northern Europe? ☐ **YES** ☐ **NO**
4. Immunosuppression, organ transplant, or Immunosuppressant medication or HIV Infection? ☐ **YES** ☐ **NO**

IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS, THEN YOU MUST COMPLETE THE TB ASSESSMENT BELOW.

PART 3: TUBERCULOSIS (TB) ASSESSMENT

NOTE: This section must be completed by a licensed health care provider. TB test's must have been taken no more than one year from the start date of July 1, 2018. Please do either the A). TST skin test OR the B). IGRA blood test. If history of BCG TB vaccine IGRA blood test is recommended.

A) TUBERCULIN SKIN TEST (TST)

Test Results should be recorded as millimeters (mm) of induration. If no induration write "0." If history of abnormal chest x-ray, recent contact with persons with active TB diseases, or is immunosuppressed then 5mm is positive. Otherwise, 10mm is positive if coming from a high risk area.

DATE TEST WAS GIVEN: _____

DATE TEST WAS READ: _____

RESULT: _____

INTERPRETATION: ☐ **NEGATIVE** ☐ **POSITIVE**

B) TB BLOOD TEST (INTERFERON GAMMA RELEASE ASSAY-IGRA)

Strongly recommended if history of BCG/TB Vaccine. If intermediate, repeat test. If positive the Chest X-Ray is required.

DATE OBTAINED: _____

INTERPRETATION: ☐ **NEGATIVE** ☐ **POSITIVE** ☐ **INTERMEDIATE**

PLEASE CONTINUE TO PAGE 2 TO COMPLETE THE CERTIFICATION OF TEST RESULTS AND CHEST X-RAY IF REQUIRED.
IF TST SKIN TEST OR IGRA BLOOD TEST IS POSITIVE THE CHEST X-RAY IS REQUIRED.

PART 4: CHEST X-RAY

NOTE: Required if TST Skin Test OR IGRA Blood Test are **positive**.

DATE OF CHEST X-RAY: _____

RESULT: ☐ **NORMAL** ☐ **ABNORMAL**

PART 5: CERTIFICATION OF TEST RESULTS

I certify that the above information is accurate and the test was administered within 12 months of the start of the program on July 1, 2018.

Licensed Healthcare Provider's Name:
(Please print in block letters) _____

Healthcare Provider Signature: _____ **DATE:** _____

Healthcare Providers Stamp: