Tuberculosis (TB) Risk Assessment

Please check any of the risk factors below that apply to you:

- Birth, travel, or residence in a country with an elevated TB rate for at least 1 month. ❑ **YES** ❑ **NO**
  Includes any country OTHER THAN the United States, Canada, Australia, New Zealand, or a country in western on northern Europe
- Immunosuppression, current or planned ❑ **YES** ❑ **NO**
  HIV infection, organ transplant recipient, treated with medications such as infliximab, etanercept, steroids (equivalent of prednisone ≥ 15 mg/day for ≥ 1 month) or other immunosuppressive medication
- Close contact with someone with INFECTIOUS TB disease during lifetime ❑ **YES** ❑ **NO**

If the answer is YES to any of the above questions, you must do ONE of the following:

- ✓ Call the Student Health Center (SHC) at (323) 343-3302 to schedule an appointment to see the **nurse** for TB clearance as soon as possible. Please bring this form and any health records such as immunization records, chest x-ray, and blood test to your appointment. If unsure, please bring the records so the nurse can review them.
- ✓ Obtain TB clearance from your own private medical provider or a community clinic. The Tuberculosis Verification form must be completed and submitted to the SHC as soon as possible. The form is available from Housing Services, Housing's website or the SHC's website.

If the answer is NO to all of the above questions, no further assessment or testing is required. Please submit this form to the Student Health Center in person, by mail (Cal State L.A. Student Health Center, 5151 State University Drive, Los Angeles, CA 90032), or by fax at (323) 343-6557.

IMPORTANT: IF THERE IS A CHANGE IN ANY RISK FACTORS LISTED ABOVE, YOU MUST RETURN TO THE SHC FOR A REPEAT TB RISK ASSESSMENT.

By my signature below: I hereby attest that my answers above are complete and accurate. I am authorizing the Student Health Center to release personal health information related to my TB clearance to the Cal State L.A. Housing Department. I agree to return to the SHC for a repeat TB risk assessment if there are changes in the risk factors listed above.

Print Name:_____ Date of Birth: _____ Gender:
Last Name First Name Month / Day / Year ☐ Male ☐ Female

_____ _____
Student's Signature OR Parent/Guardian's Signature (if student is under age 18) Date

THIS SECTION FOR SHC PERSONNEL ONLY

- ☐ TB risk assessment completed.
- ☐ TB testing done. See visit note.
- ☐ Patient has a history of positive TB test. See visit note.
- ☐ Patient has records related to TB clearance (chest x-ray, blood test, etc.). See visit note.

Comments:_____

_____
Nurse's Signature Date

California State University, Los Angeles
STUDENT HEALTH CENTER

TUBERCULOSIS (TB) RISK ASSESSMENT

Last Name_____

First_____

CIN_____