



TUBERCULOSIS FORM

STUDENT INFORMATION

Last Name:		First Name:			Middle Initial:		
Drexel University ID:		DOB:			Date of Entry into Drexel:		
Program (check one):	ACE <input type="checkbox"/> HSAD	Co-op DNP	CAT COFT	MSN: NP NUAN	NS/ISPP PTRS	PA DPT	MSN: Advanced Role Other

TEST MUST BE PERFORMED IN THE U.S. WITHIN 12 MONTHS OF THE START OF SCHOOL.

Interferon Gamma Release Assay (IGRA) **THIS IS REQUIRED FOR THE FOLLOWING PROGRAMS: ACE, CAT, COFT, Co-Op, DNP, DPT, MSN, NP, NUAN, PA, & PTRS PROGRAMS.

Date Obtained (Attach results of laboratory test):	Please check one: <input type="checkbox"/> T-Spot <input type="checkbox"/> Quantiferon	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate	IF POSITIVE RESULT: See Chest X-Ray Information below.
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PPD Tuberculin Skin Test (Mantoux 2nd Step must be within 1-3 weeks.) **THIS IS NOT ACCEPTED FOR THE FOLLOWING PROGRAMS: ACE, CAT, COFT, Co-Op, DNP, DPT, MSN, NP, NUAN, PA, & PTRS PROGRAMS.

1 st PPD Tuberculin Skin Test (Must be performed in the United States)	Date given (healthcare provider must initial):	Date read (healthcare provider must initial):	Result: _____ mm induration <input type="checkbox"/> Negative <input type="checkbox"/> Positive	IF POSITIVE PPD RESULT: See Chest X-Ray Information below.
2 nd PPD Tuberculin Skin Test (Must be performed in the United States)	Date given (healthcare provider must initial):	Date read (healthcare provider must initial):	Result: _____ mm induration <input type="checkbox"/> Negative <input type="checkbox"/> Positive	

TEST MUST BE PERFORMED IN THE U.S. WITHIN 12 MONTHS OF THE START OF SCHOOL.

Chest X-Ray Information: required if tuberculin skin test or IGRA test is positive. (Copy of X-ray or IGRA must also be attached.)

Date of Chest X-Ray (must be done in the United States):	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Date treatment started: (if abnormal results)	Date treatment completed: (if abnormal results)
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HEALTH CARE EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this page (2) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.

Health Care Examiner's Name (Please Print):

License #:	Phone:
Signature of Health Care Examiner:	Date: