DREXEL UNIVERSITY
College of
Nursing and
Health Professions

TUBERCULOSIS FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN** ☐ PTRS ☐ DPT ☐ Other

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

Interferon Gamma Release Assay (IGRA)

Date Obtained *(Attach results of laboratory test)*:	Please check one: ☐ T-Spot ☐ Quantiferon	Result: ☐ Negative ☐ Positive ☐ Indeterminate	IF POSITIVE RESULT: See Chest X-Ray Information below.

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: ☐ Normal ☐ Abnormal	Date treatment started: *(if abnormal results)*	Date treatment completed: *(if abnormal results)*

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:**