



# TUBERCULOSIS FORM

PAGE 2

## STUDENT INFORMATION

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

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

#### Interferon Gamma Release Assay (IGRA)

Date Obtained <i>(Attach results of laboratory test):</i>	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	<b>IF POSITIVE RESULT:</b> See Chest X-Ray Information below.
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### 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 <i>(must be done in the United States):</i>	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Date treatment started: <i>(if abnormal results)</i>	Date treatment completed: <i>(if abnormal results)</i>
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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: