










Dear Incoming Student,

In order to protect our campus from communicable disease, **all new and re-admitted graduate and undergraduate students are required to complete a Tuberculosis Screening before arriving at UC San Diego.**

Please read and follow the instructions below to complete your TB Screening:

-  1. **Log in to MyStudentChart.** In order to log in to MyStudentChart, you will need your AD username and password.
-  2. Once logged in, you will find “**Announcements**” on the home page. The first item on this list is “**Incoming Student Health Requirements.**”
-  3. Click on the hyperlink “**self-enter and upload documents in MyChart.**”
-  4. Click to start the **TB Screening**. Answer all the screening questions.
-  5. **If the screening prompts you** to submit your TB Testing Form, please complete **steps 6-9** below.
-  6. **Print the TB Health Assessment Form** (page 2 of this document).
-  7. **Visit your health care provider** to complete the form and perform all required testing. **The form must be signed by a licensed health care provider.**
-  8. Tuberculosis testing must be performed **within 1 year before the start of your program.**
-  9. **Upload your TB Testing Form** to: MyStudentChart.ucsd.edu. Do not upload this instruction page to MyStudentChart. Only upload page 2 of this document (the Tuberculosis Testing Form) to MyStudentChart.

Questions:

- If you have a **clinical question**, use the “ASK A NURSE” function in your electronic medical record: MyStudentChart.ucsd.edu.
- If you are having **technical problems**, email shstb@health.ucsd.edu and include your student ID number. **Do not include any medical information** as this is not a secure method of communication.
- Please refer to the [Student Health Services website](#) for additional information.

TUBERCULOSIS TESTING REQUIREMENT

Student ID:	Date of Birth: (MM/DD/YYYY)	Name: First Last
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THIS STUDENT IS REQUIRED TO COMPLETE TUBERCULOSIS TESTING PRIOR TO ENROLLING IN CLASSES. The form must be **completed and signed by a LICENSED HEALTH CARE PROVIDER** and must be received by UCSD Student Health via Health Record upload, noted at the bottom of the page.

TESTING MUST BE performed within one year of entering the University.

AS RECOMMENDED BY THE CDC TB SKIN & BLOOD TESTING MUST OCCUR AT LEAST 4 WKS FOLLOWING THE COVID-19 VACCINE

1. SYMPTOMS: No current symptoms

Does your patient have any of the following symptoms? (check any that apply)

Cough for greater than 4 weeks Coughing up blood Unexplained chest pain Persistent fever/chills/night sweats

Persistent, unexplained fatigue Unexplained weight loss

2. TUBERCULIN SKIN TEST (TST)	- OR -	3. TB BLOOD TEST (recommended if history of BCG/TB Vaccine)
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≥ 5 mm is positive if:

- Recent close contact with someone with active infectious TB disease
- Immunosuppressed (splenectomy, HIV, chemotherapy, transplant patient)
- History of an abnormal chest x-ray suggestive of TB

otherwise ≥ 10mm is positive

Date placed: _____ Date read: _____
(must be read between 48-72 hours after it was placed)

Result: ____ mm induration. (If no induration, write Ø)

Interpretation: **Negative** **Positive**
(IF POSITIVE, PROCEED TO CHEST X-RAY)

****ALL FIELDS MUST BE COMPLETED TO AVOID DELAYS**

QUANTIFERON - Interferon Gamma Release Assay – IGRA
If not available, may do a Tuberculin Skin Test (TST) or Chest x-ray.

Date QTF Test: _____

Result: **Negative** **Positive**
(If positive, proceed to **CHEST X-RAY**)

Indeterminate
(If Indeterminate, repeat test or proceed to chest x-ray)
(IF POSITIVE, PROCEED TO CHEST X-RAY)

4. CHEST X-RAY REQUIRED if TST or Quantiferon/IGRA +/- symptoms are positive or previous treatment for TB

YOU MUST ATTACH WRITTEN RADIOLOGY CHEST X-RAY REPORT IN ENGLISH (DO NOT SEND FILMS/CD of actual x-ray)

Any abnormal result, including scars and old granulomatous changes – MUST PERFORM SPUTUM TESTING

Date of chest x-ray: _____ Result: Normal Abnormal

(Results submitted without chest x-ray report will NOT be accepted.)

5. TB SPUTUM

Results (AFB smear and cultures x3 are REQUIRED if the chest x-ray is read as ABNORMAL)

1. Date: _____ AFB: _____ Culture: _____

2. Date: _____ AFB: _____ Culture: _____

3. Date: _____ AFB: _____ Culture: _____

6.

Licensed Health Care Provider Name	Signature	Date

7. Upload PDF or image to: [MyStudentChart.ucsd.edu/shs/](https://mystudentchart.ucsd.edu/shs/)