Yale HEALTH

55 Lock Street, New Haven, CT 06511

# Yale University Student Health Requirements Information

## READ ALL INFORMATION AND FOLLOW INSTRUCTIONS CAREFULLY TO AVOID ERRORS AND OMISSIONS

Dear Yale University Student,

On behalf of Yale University and Yale Health, we wish you the warmest welcome!

This packet outlines health requirements that must be completed prior to your established deadline for your program.

These requirements are mandated by Yale University policy and Connecticut State regulations**. If you do not complete health requirements before your established deadline, you may be blocked from registering for classes in the future.**

**Key Points:**

- **Forms:** Several forms require a signature from your healthcare provider.
- **Act Now: We strongly recommend that you schedule your appointment with your healthcare provider NOW**. Many providers are busy during the summer months and wait times may be long.
- **Deadlines:** You must complete health requirements by the established deadline for your program.

We know that you have much to complete prior to coming to campus, therefore we have provided a checklist and forms within this packet to help make sure this process is as straightforward as possible.

Yale Health at Yale University.

Yale HEALTH

55 Lock Street, New Haven, CT 06511

# Yale University Student Health Requirements Checklist

**Documents within this packet:**

| FORM NAME | RECOMMENDED ACTION | ❒ CHECKLIST ✓ |
|---|---|---|
| Health Requirements Information | Read general welcome to the Health Requirements Information | ❒ Reviewed this page |
| Vaccination and Titer (blood test) information | Read information about vaccinations and titers (blood test) | ❒ Reviewed this page |
| Health Portal Information | Read general information about Yale's Health Portal | ❒ Reviewed this page |
| Authorization for Medical Care and Treatment for Minors | Only for Students under the age of 18 at the time of admission.<br>- Parent or Guardian must read and sign this document.<br>- Email completed form to yhmedicalrecords@yale.edu. | ❒ Parent or Guardian signs document<br>❒ Document sent to Yale Health. |
| Student Health and Physical Exam Form | - Fill out the top demographic section with your information.<br>- Take this form to your medical provider to be completed.<br>- Email completed form to yhmedicalrecords@yale.edu | ❒ Demographic section filled out.<br>❒ Healthcare provider completes form and signs it.<br>❒ Document sent to Yale Health. |
| Student Immunization and TB Testing History Form | - Fill out the top demographic section with your information.<br>- Take this form to your medical provider to be completed.<br>- Health Professionals Students must have TB Testing completed.<br>- Submit this form to the portal. | ❒ Demographic section filled out.<br>❒ Healthcare provider completes form and signs it.<br>❒ Document uploaded to the portal. |
| Student Tuberculosis (TB) Risk Assessment Form (Not to be filled out by Health Professionals Students) | - Fill out the top demographic section with your information.<br>- Take this form to your medical provider to be completed.<br>- Submit this form to the portal. | ❒ Demographic section filled out.<br>❒ Healthcare provider completes form and signs it.<br>❒ Document uploaded to the portal. |

**Important Dates for the Academic Year**
**(dates are approximate)**

| Documentation | Fall Semester | Spring Semester | Summer Session |
|---|---|---|---|
| Received Admissions Packet with Health Requirements Information | Early May | Fall | January to May |
| Compile Health Requirements and Obtain Physical Exam | May – July | October – November | January to May |
| Log into Health Portal with Yale Net ID | End of July | End of November | Mid February |
| Activate your Yale MyChart with Activation Code received via mail | End of July | End of November | Late April<br>*Not Applicable to Non-Degree Seeking Students |
| Submissions Deadline for Health Requirements | August 1 | December 15 | Session A – April 15<br>Session B – May 20 |
| Semester Begins | Late-August, 2024 | Mid-January | Session A – Late May<br>Session B – Late June |
| Get Required Influenza Vaccination | December 1st ** | Must be completed prior to matriculation | *Not Applicable* |

** Earlier date requirements may be in place for your specific cohort or program. Check with your school for details.

Yale HEALTH

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## Yale University Vaccination and Titer (blood test) Information

**THE FOLLOWING ARE REQUIRED FOR ALL INCOMING STUDENTS**

1. **Measles, Mumps, Rubella (MMR)**
    a. Option 1 – Vaccination
        i. Required to have two (2) doses. The first dose must be given on or after your first birthday, the second dose must be at least 28 days from the first dose.
        ii. If the above is not satisfied, please obtain a booster dose and enter that date.
    b. Option 2 – Titer (blood test)
        i. A titer showing immunity to each disease (Measles, Mumps and Rubella) is an acceptable alternative to vaccination. Lab records must be included as proof.

2. **Varicella (Chicken Pox) Immunity**
    a. Option 1 – Vaccination
        i. Required to have two (2) doses. The first dose must be given on or after your first birthday, the second dose must be at least 28 days from the first dose.
    b. Option 2 – Titer (blood test)
        i. A titer showing immunity to Varicella is an acceptable alternative to vaccination. Lab records must be included as proof.
    c. Option 3 – Certification of Past Disease
        i. Your medical provider can certify the date you had Varicella (Chickenpox) which would provide your immunity.

3. **Meningococcal Vaccination**
    a. Option 1 – Vaccination
        i. Vaccination required for all students living in university dormitories.
        ii. Vaccine must have been given WITHIN five (5) years of your first day of class.
        iii. Must cover strains A, C, Y, W-135)
    b. Option 2 – Exemption to requirement
        i. If you will not be living in university dormitories, you can elect to be exempt from this requirement by checking the applicable box.

4. **Tuberculosis (TB) Risk Assessment**
    a. All Non-Health Professionals Students are required to complete the Tuberculosis (TB) Risk Assessment Form.
    b. Students to complete the demographic information AND Part 1 of the form.

i. If you answer YES to any of the screening questions, your medical provider must complete Part 2.

c. TB Testing is ONLY required for those who have a YES answer to any of the screening questions.

**THE FOLLOWING ITEMS ARE REQUIRED ONLY FOR HEALTH PROFESSIONS STUDENTS**

5. **Tuberculosis (TB) Screening**
   a. Screening consists of one of the following.
      i. TB Blood Test / IGRA (preferred)
         1. Must be within 6 months of matriculation date.
      ii. Skin testing / PPD
         1. Must be within 6 months of matriculation date.
   b. Positive screening tests must be followed up by Chest Xray and documentation of any treatment for TB.

6. **COVID-19 Vaccination (WHO approved)**
   a. Must be up-to-date with the most recent COVID vaccine
      i. Updated 2023-2024 mRNA vaccine (Pfizer or Moderna)
      ii. Updated 2023-24 protein subunit vaccine (Novavax)
   b. Please provide documentation of prior primary series doses of WHO approved COVID-19 vaccines in the space provided.

7. **Hepatitis B Immunity (must complete both)**
   a. Vaccination – Completed series (2 dose or 3 dose) Hepatitis B vaccination.
   b. Titer (blood test) – Quantitative Hepatitis B Surface Antibody titer
      i. Must have a numerical result indicating immunity.
      ii. Qualitative (tests that say Immune or Not immune only) are not accepted.
      iii. Titer can be performed at any time following vaccination; does not need to be recent as long as it indicates immunity.

8. **Tetanus – Diphtheria – Pertussis (Tdap) Vaccination**
   a. Vaccination within the past 10 years.

9. **Influenza Vaccination**
   a. Vaccination completed each academic year completed between September and March.
   b. Students in Online Physician Associate – Online Program MUST have this completed prior to matriculation.

Yale HEALTH

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# Yale University Health Portal Information

Yale Health uses *Medicat** as their current health portal. You can access this portal via https://yale.medicatconnect.com (you will need your NET ID, emailed to you separately).

This system allows students to upload all of their required health information for processing, review and storage. This system was created to provide a single place for students to address any health requirements they may have based on their health status and educational affiliation.

Once you receive your NET ID from Yale you will have access to the health portal to begin uploading the information from this packet.

Please double check all forms prior to uploading them to the portal to avoid unnecessary delays in processing. Any forms filled out by your medical provider need to be signed by the provider or they are not valid.

**All documentation must be provided in English (or translated to English) prior to submitting for review.**

In addition, vaccine, or titer (blood test) information must be entered onto the forms. Attached vaccination records and/or lab test results will result in delays and errors in completing health requirements.

You ***must*** go to the health portal and ENTER ALL DATES for your various vaccines and or titers in addition to uploading the required forms/documentation.

If you have concerns or questions about a specific requirement, you can contact the Campus Health team via the portal. If you have other issues, questions or concerns please email campushealthcompliance@yale.edu .

Yale Health at Yale University.

*Yale is planning a transition to a new health portal. If this change affects you, you will be notified.

Yale HEALTH

**Email to yhmedicalrecords@yale.edu (preferred)**
**Mail: P.O. Box 208237, New Haven, CT 06520**
**Fax: 203-436-5536**

# Yale University Authorization for Medical Care and Treatment for Minors

**THIS FORM IS REQUIRED FOR ALL STUDENTS UNDER 18 YEARS OF AGE.**

| **Last Name** | **First Name** | **Date of Birth:** ___ -___ -_____ Month Day Year | | **Chosen Name** |
|---|---|---|---|---|
| **E-mail** | **Phone** | **Sex Assigned at Birth** | **Gender Identity** | **Pronouns** |
| **Department/Program of Study at Yale** (Check one) ❒Undergraduate ❒Graduate ❒Summer ❒School of Medicine ❒School of Nursing ❒Physician Associate Program | | | | |

Yale Health Center requests that at the time of admission, the parents, or legal guardians of students under the age of 18 provide written authorization for Yale Health Center to provide medical care and treatment, including mental health and counseling services, to minor students.

**The undersigned hereby grants permission for medical care and treatment, including mental health and counseling, to be provided by Yale Health Center staff to:**

_____ _____

Printed Name of Parent/Guardian | Relationship to Student

_____ _____

Signature of Parent/Guardian | Date

Yale HEALTH

**Email to yhmedicalrecords@yale.edu (preferred)**
**Mail: P.O. Box 208237, New Haven, CT 06520**
**Fax: 203-436-5536**

# Yale University Student Health and Physical Exam Form

| **Last Name** | **First Name** | **Date of Birth:** ____ -___ -_____ MM DD YYYY | **Chosen Name** |
|---|---|---|---|
| **E-mail** | **Phone** | **Sex Assigned at Birth** | **Gender Identity** / **Pronouns** |

**Department/Program of Study at Yale** (Check one)
❒Undergraduate ❒Graduate ❒Summer ❒School of Medicine ❒School of Nursing ❒Physician Associate Program

| **Home Address** / **City/State** / **ZIP** | **Parent/Guardian Home Phone** | **Parent/Guardian Work Phone** |
|---|---|---|
| | | |

| **Emergency Contact Name** | **Emergency Contact Relationship** | **Emergency Contact Phone** |
|---|---|---|
| | | |

**Health History | To be completed by Medical Provider**

| | **Height** | **Weight** | **Blood Pressure:** | **Pulse:** | |
|---|---|---|---|---|---|
| **Vital Signs** | _____ inches | _____ lbs | _____/_____ Systolic / Diastolic | _____ bpm | |

**Allergies**

Allergies to medications? ❒ NO ❒ YES – please list:_____
_____

Severe Food Allergy? ❒ NO ❒ YES – please list:_____
_____

If this patient receives allergy immunotherapy, please complete the Student Allergy Medical Treatment Plan* form.

**Current Medications**

Please list: _____
_____
_____

**Vitamins Supplements Over The Counter(s)**

Please list: _____
_____
_____

**Current or past medical, surgical, or psychiatric condition(s)**

Please list: _____
_____
_____
_____
_____



* This form is available on the Yale Health website *yalehealth.yale.edu*

| Clinical Evaluation | Normal | Abnormal | Comments |
|---|---|---|---|
| **Skin** | | | |
| **Head, ears, eyes, nose, throat, hearing and visual acuity** | | | |
| **Mouth, teeth and gums** | | | |
| **Neck and thyroid** | | | |
| **Lungs/Chest** | | | |
| **Breasts** | | | |
| **Heart (supine and upright)** | | | |
| **Abdomen** | | | |
| **Genitalia** | | | |
| **Back/Spine** | | | |
| **Extremities/Musculoskeletal/Femoral Pulses** | | | |
| **Neurologic** | | | |
| **Emotional/Psychological** | | | |
| **Other findings** | | | |

**Part 4: Medical Provider Certification of the Above Information**

I have reviewed the medical history and examined the student noted above; the information is accurate and complete to the best of my knowledge. The student is cleared medically and psychologically to participate in the demands of college life.

❒ Yes/Unlimited activity and fit for college

❒ No/Limited activity

Reason: _____

Recommendations: _____

_____

| **Medical Provider Name** | **Medical Provider Signature** | **Date** |
|---|---|---|
| **Address** (Include city and state) | | **Telephone** |
| **Email** | | **Fax** |

Yale HEALTH

**Submit Form to Health Portal**

# Yale University Student Immunization and TB Testing History Form

**THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY. DATES MUST BE ENTERED ON THIS FORM. DO NOT ATTACH A SEPARATE VACCINATION RECORD. All dates must in MM-DD-YYYY format.**

| Last Name | First Name | Date of Birth: ___ -___ -_____ MM DD YYYY | Chosen Name | |
|---|---|---|---|---|
| **E-mail** | **Phone** | **Sex Assigned at Birth** | **Gender Identity** | **Pronouns** |
| | | | | |

**Department/Program of Study at Yale** (Check one)

❒Undergraduate * ❒Graduate * ❒Summer * ❒School of Medicine ± ❒School of Nursing ± ❒Physician Associate Program ±

## Part 1: Required for all Students

### IMMUNIZATION HISTORY

**1. MEASLES, MUMPS, RUBELLA (MMR) IMMUNITY – * ± Required for all students**

| | | | | |
|---|---|---|---|---|
| **Option 1** | Measles, Mumps, Rubella (MMR) Vaccination<br>• First dose must be given on or after your first birthday; second dose must be at least 28 days from first dose.<br>• If above not satisfied, obtain a booster and enter date given, or complete Option 2. | Dose #1: ___ -___ -_____ Month Day Year | Dose #2: ___ -___ -_____ Month Day Year | Booster (if indicated): ___ -___ -_____ Month Day Year |
| **Option 2** | In lieu of proof of vaccination above, a titer showing immunity to each individual disease is an acceptable alternative to vaccination.<br>**LAB RESULTS MUST BE ATTACHED** | Measles Titer Result: ❒ Immune* ___ -___ -_____ Month Day Year<br>Mumps Titer Result: ❒ Immune* ___ -___ -_____ Month Day Year<br>Rubella Titer Result: ❒ Immune* ___ -___ -_____ Month Day Year | *If not immune, you are required to receive a booster and repeat the titer. | |

**2. VARICELLA IMMUNITY – * ± Required for all students born after 1979**

| | | | |
|---|---|---|---|
| **Option 1** | Varicella Vaccination – first dose must be given on or after your first birthday to be accepted. | Dose #1 ___ -___ -_____ Month Day Year | Dose #2: ___ -___ -_____ Month Day Year |
| **Option 2** | In lieu of proof of vaccination above, a titer showing immunity is an acceptable alternative to vaccination.<br>**Required**: ❒ Attach lab results | Varicella Titer Result: ❒ Immune* ___ -___ -_____ Month Day Year | *If not immune, you are required to receive a booster and repeat the titer. |
| **Option 3** | An incidence of disease will take the place of a vaccine requirement. (Must be filled in by an MD/DO/APRN/PA-C.) | Varicella disease: ___ -___ -_____ Month Day Year | |

**3. MENINGOCOCCAL Vaccination – * ± Required of all undergraduate and graduate students living in university dormitories**

| | | |
|---|---|---|
| Meningitis Vaccine (MCV 4)<br>Must cover strains A, C, Y, W-135 (Menactra, Menveo or Nimenrix) | Date: ___ -___ -_____ Month Day Year<br>Vaccination MUST have been given WITHIN 5 years of your first day of class at Yale. | **Exceptions to requirement:**<br>❒ I will not be living in university-owned dormitories. |

## Part 2: Required for all Health Professions Students

**4. TUBERCULOSIS (TB) – ± Required for Health Professions Students – All other students to complete TB Risk Assessment Form (in packet)**

| STEP 1: TB Blood Test/IGRA OR TB Skin Test (PPD) | | STEP 2: DO NOT COMPLETE UNLESS POSITIVE TB SKIN TEST OR TB BLOOD TEST | |
|---|---|---|---|
| ❒ QuantiFERON ❒ T-Spot<br>Date: ___ -___ -_____<br>Month Day Year<br>RESULT: ❒ NEG ❒ POS*<br>**Required: ❒ Attach lab results.** | Date planted: ___ -___ -_____<br>Month Day Year<br>Date read: ___ -___ -_____<br>Month Day Year<br>Interpretation: ❒ NEG ❒POS*<br>mm of induration: _____ | **CHEST XRAY**<br>Required if past or current positive TB skin or blood test. Not required if completed medication treatment for TB.<br>Chest X-ray Date: ___ -___ -_____<br>Month Day Year<br>❒ Normal ❒Abnormal | **TB TREATMENT**<br>❒ Latent TB Infection<br>❒ Active TB Infection<br>Date(s): ___ -___ -_____<br>Month Day Year<br>List Medication(s): |

**5. COVID-19 VACCINATION – ± Required for Health Professions Students – Strongly encouraged for all other students.**
- **Please submit documentation of prior vaccine doses AND at least one (1) dose of 2023-2024 updated formulation.**

| PRIMARY DOSE #1 | PRIMARY DOSE #2 (skip if J&J vaccine) | COVID-19 updated 2023-2024 dose |
|---|---|---|
| Date: ___ -___ -_____<br>Month Day Year<br>❒ Moderna<br>❒ Pfizer<br>❒ Johnson & Johnson/Janssen<br>❒ Novavax<br>❒ Other WHO approved<br>Name: | Date: ___ -___ -_____<br>Month Day Year<br>❒ Moderna<br>❒ Pfizer<br>❒ Novavax<br>❒ Other WHO approved<br>Name: | Date: ___ -___ -_____<br>Month Day Year<br>❒ Moderna<br>❒ Pfizer<br>❒ Novavax |

**6. Hepatitis B Immunity – ± Required for Health Professions Students – Not required for all other students.**
**Documentation of a COMPLETE series of Hepatitis B vaccination AND quantitative antibody titer.**

| Hepatitis B Vaccine (enter name) | Date of Dose #1: ___ -___ -_____<br>Month Day Year | Date of Dose #2: ___ -___ -_____<br>Month Day Year | Date of Dose #3 (if applicable): ___ -___ -_____<br>Month Day Year | Hep B Surface Antibody Titer (QUANTITATIVE)<br>___ -___ -_____<br>Month Day Year<br>Result: _____ IU / sc<br>❒ Immune ❒ Not Immune |
|---|---|---|---|---|

**7. TETANUS-DIPTHERIA-PERTUSSIS (Tdap) – ± Required for Health Professions Students – Not required for all other students.**

| Only Tdap is accepted within the past 10 years | Date of most recent Tdap dose: ___ -___ -_____<br>Month Day Year |
|---|---|

**8. INFLUENZA VACCINATION: ± Required for Health Professions Students, documentation to be submitted during flu season. Recommended but not required for all other students.**

| Influenza (Flu) Vaccination | Date of Influenza Vaccination: ___ -___ -_____<br>Month Day Year<br>Must be between September and March of CURRENT academic year |
|---|---|

## Part 3: Recommended vaccines based on personal history – (please record if applicable)

| **OTHER VACCINES - NOT required** | | | | |
|---|---|---|---|---|
| **Hepatitis A Vaccine** | Date of Dose #1: ___ -___ -_____ Month Day Year | Date of Dose #2: ___ -___ -_____ Month Day Year | | |
| **HPV Vaccine** | ❒ HPV 4<br>❒ HPV 9 | Date of Dose #1: ___ -___ -_____ Month Day Year | Date of Dose #2: ___ -___ -_____ Month Day Year | Date of Dose #3: ___ -___ -_____ Month Day Year |
| **Meningococcal Serogroup B Vaccine** | ❒ Bexsero, 2 doses<br>❒ Trumenba, 3 doses | Date of Dose #1: ___ -___ -_____ Month Day Year | Date of Dose #2: ___ -___ -_____ Month Day Year | Date of Dose #3 (if Trumenba): ___ -___ -_____ Month Day Year |
| **Yellow Fever** | ❒ Yellow Fever<br>❒ Stamaril | Date of Dose: ___ -___ -_____ Month Day Year | | |
| **Typhoid** | Date of Dose: ___ -___ -_____ Month Day Year | | | |

## Part 4: Medical Provider Certification of the Above Information

| **Medical Provider Name** | **Medical Provider Signature** | **Date** ___ -___ -_____ Month Day Year |
|---|---|---|
| **Address** (Include city and state) | | **Telephone** |
| **Email** | | **Fax** |

Yale HEALTH

**Submit Form to Health Portal**

# Yale University Student Tuberculosis (TB) Risk Assessment and Testing Form

**THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY. DATES MUST BE ENTERED ON THIS FORM.**
**All dates must in Month-Day-Year format.**

| Last Name | First Name | Date of Birth: ____ -____ -_____ Month Day Year | Chosen Name | |
|---|---|---|---|---|
| **E-mail** | **Phone** | **Sex Assigned at Birth** | **Gender Identity** | **Pronouns** |
| **Department/Program of Study at Yale** (Check one) ❒Undergraduate ❒Graduate ❒Summer HEALTH PROFESSIONS STUDENTS DO NOT COMPLETE THIS FORM – TB TESTING IS REQUIRED FOR YOUR PROGRAMS AND IS DOCUMENTED ON THE IMMUNIZATIONS AND TB TESTING FORM | | | | |

**Part 1: Students complete this section – If you answer YES to any question your medical provider must complete Part 2.**

| TUBERCULOSIS RISK ASSESSMENT | | |
|---|---|---|
| **Section A: History of TB** | | |
| 1. Have you ever been sick with (had symptoms and diagnosed) TB? | ❒ Yes | ❒ No |
| 2. Have you ever had a positive TB Test (PPD, QuantiFERON test or T-Spot)? | ❒ Yes | ❒ No |
| **Section B: Risk Assessment for TB** | | |
| 1. Were you born in, or have you lived, worked, or visited for more than one (1) month any country not including the following: United States, Canada, Australia, New Zealand, Northern or Western European country? | ❒ Yes | ❒ No |
| 2. Do you have current or planned immunosuppression due to: HIV Infection, organ transplant recipient, treatment with a TNF-blocker (e.g. infliximab, etanercept, or others), chronic steroids, other immunosuppressive medications? | ❒ Yes | ❒ No |
| 3. Do any of the following conditions or situations apply to you? | | |
| a. Do you have a persistent cough (three (3) weeks or more), fever, night sweats fatigue, loss of appetite or unexplained weight loss? | ❒ Yes | ❒ No |
| b. Have you ever lived with or been in close contact with a person known or suspected of being sick with TB? | ❒ Yes | ❒ No |
| c. Have you ever lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home, or residential healthcare facility? | ❒ Yes | ❒ No |

**Student Signature: _____** **Date: _____**

If you answered no to all the above questions, skip Part 2; you are finished with this form.
***If you answered YES to any of the above questions, your healthcare provider must complete Part 2 on the next page.***

**Part 2: TB Testing to be completed by Medical Provider**

**ATTENTION HEALTHCARE PROVIDER:** If the patient answered **YES** to any above questions, proof of a QuantiFERON Gold / T-Spot (preferred) OR PPD skin test is **REQUIRED**. If QuantiFERON Gold / T-Spot results are positive OR PPD results are 10mm or more, a Chest X-ray is **REQUIRED**. Testing must be done within six (6) months prior to admittance (unless history of positive TB testing). If there is a history of positive TB testing, a chest x-ray is required. History of BCG vaccination does not prevent testing of someone in a high-risk group.

Documentation of any Treatment for Latent or Active TB must also be recorded below.

<table>
<tr><th colspan="4">TUBERCULOSIS (TB) Testing – Required for Students with Positive Risk Assessment Screen</th></tr>
<tr><th colspan="2">STEP 1: TB Blood Test/IGRA OR TB Skin Test (PPD)</th><th colspan="2">STEP 2: *DO NOT COMPLETE UNLESS POSITIVE TB SKIN TEST OR TB BLOOD TEST</th></tr>
<tr>
<td>❒ QuantiFERON ❒ T-Spot<br><br>Date: ____ -____ -_____<br>Month Day Year<br><br>RESULT: ❒ NEG ❒ POS*<br><br>Required: ❒ Attach lab results.</td>
<td>Date planted:<br>____ -____ -_____<br>Month Day Year<br>Date read:<br>____ -____ -_____<br>Month Day Year<br>Interpretation: ❒NEG<br>❒POS*<br><br>mm of induration: _____</td>
<td>CHEST XRAY<br>Required if past or current positive TB skin or blood test. Not required if completed medication treatment for TB.<br>Chest X-ray Date:<br>____ -____ -_____<br>Month Day Year<br>❒ Normal ❒ Abnormal</td>
<td>TB TREATMENT<br>❒ Latent TB Infection<br>❒ Active TB Infection<br><br>Date(s): ____ -____ -_____<br>Month Day Year<br>List Medication(s):</td>
</tr>
<tr>
<td>If positive TB test but no treatment was completed, please document why:</td>
<td colspan="3">❒ Patient counseled about risk/benefit of treatment of LTBI but ultimately refused.<br><br>❒ Other (specify):</td>
</tr>
</table>

| **Medical Provider Name** | **Medical Provider Signature** | **Date** |
|---|---|---|
| **Address** (Include city and state) | | **Telephone** |
| **Email** | | **Fax** |