ENVIRONMENTAL HEALTH & SAFETY
UNIVERSITY of WASHINGTON

UW HEALTH SCIENCES IMMUNIZATION PROGRAM

Positive TB Screening Form

This OPTIONAL form explains documentation requirements for students who have a positive PPD or IGRA. Health care providers (MD, DO, ARNP, PA, RN or other appropriate designee) may use this form to document a positive PPD and/or completed prophylactic treatment if other documentation is unavailable. This form is not acceptable when completed by a student or relative. Students submitting this form must complete the separate REQUIRED TB Symptom Survey Form and upload all required documentation together.

Student Name:______________________________________UW ID# __________________
PLEASE PRINT: Last name First name

Positive PPD: If student has had a positive TB skin test (*greater than or equal to 10mm*), note below the date and result of the positive test. If documentation is not available, the provider may verify the student's history by noting it below.

PPD placed: _____/____/______ PPD read: _____/____/_____ PPD result: __________mm
Mo Date Yr Mo Day Yr *A positive result is ≥10 mm.*

~ OR ~

Positive IGRA: A lab report *must be submitted* with this form (verbal history not accepted)

~ AND ~

Chest x-ray: Students with documentation of a positive PPD or IGRA must **also** submit either:

☐ A copy of a chest x-ray report (not the actual film) for an x-ray **date *after* the positive TB screening AND within the current calendar year of entry into your program.**

~ OR ~

☐ The dates of a course of completed prophylactic treatment (below) and a CXR report (not the actual film) from any date ***after* the positive TB screening**.

UW health sciences students with a positive PPD or IGRA are not required to complete prophylactic treatment. **For student who did complete prophylactic treatment**, please complete the information below. If documentation is not available, the provider may verify the student's treatment history by noting it below.

Rx/medication type: ____

Date started: _____/____/______ Date ended: _____/_____/_____ Length of treatment: _____months
Mo Date Yr Mo Date Yr

For students with a history of active TB disease: Please contact HSIP at myshots@uw.edu for instructions.

Required: Health Care Provider Authentication
I certify the accuracy of the dates and other information on this form.

Signature:____ **circle one**: MD, ARNP, PA, DO, ND, RN

Printed Name: ________________________________

Phone #:______________________ Date: ____________

FACILITY STAMP