TUBERCULOSIS (TB) HEALTH ASSESSMENT FORM UNIVERSITY OF CALIFORNIA, LOS ANGELES

Student ID:	Date of Birth: (MM/DD/YYYY)	Name: First Last

For incoming students who answered "YES" to any of the questions on the *Tuberculosis Risk Screening Questionnaire* on the Ashe Secure Portal
OR
If you are a Healthcare Professional Student (Medical/Dental/Nursing/Social Welfare) please complete section below:

TUBERCULIN SKIN TEST (TST) Vaccine)	**OR**	**TB BLOOD TEST (Recommended if history of BCG/TB**
One skin test required for NON-Healthcare Professional Students: **Date placed**:_____ **Date read**:_____ (must be read between 48-72hrs after it was placed) **Result**: _____ mm induration. Interpretation: ☐ **Negative** ☐ **Positive** **(IF POSITIVE, PROCEED TO SYMPTOMS & BLOOD TEST OR CHEST X-RAY)**		**QUANTIFERON or T-SPOT** **(Interferon Gamma Release Assay – IGRA)** If not available, may do a Tuberculin Skin Test (TST) or Chest X-ray. **Date QTF/T-SPOT Test**: _____ Result: ☐ **Negative** ☐ **Positive** **(IF POSITIVE, PROCEED TO SYMPTOMS & CHEST X-RAY)** ☐ **Indeterminate** **(IF INDETERMINATE, REPEAT TEST OR PROCEED TO CHEST X-RAY)**
Two skin tests required for Healthcare Professional Students: **Date placed**:_____ **Date read**: (must be read between 48-72hrs after it was placed) **Result**: _____ mm induration. Interpretation: ☐ **Negative** ☐ **Positive** **(IF POSITIVE, PROCEED TO SYMPTOMS & BLOOD TEST OR CHEST X-RAY)**		

SYMPTOMS:
Does your patient have any of the following symptoms? (please check any that apply)
☐ Cough for greater than 4wks ☐ Coughing up blood ☐ Unexplained Chest pain ☐ Persistent fever/chills/night sweats ☐ Persistent, unexplained fatigue ☐ Unexplained weight loss

CHEST X-RAY (REQUIRED if TST or Quantiferon/IGRA +/or Symptoms are positive OR previous treatment for TB)

Date of Chest x-ray:_____ **Result:** ☐ Normal ☐ Abnormal
MUST ATTACH <u>WRITTEN</u> RADIOLOGY CHEST XRAY REPORT IN ENGLISH (DO NOT SEND FILMS/CD of actual X-ray)

MD/PA/NP		(MM/DD/YYYY)
Licensed Health Care Provider Name	Signature	Date

UNIVERSITY OF CALIFORNIA, LOS ANGELES IMMUNIZATION REQUIREMENTS

Student ID:	Name:

REQUIRED IMMUNIZATIONS	
COVID-19	**PRIOR TO ENROLLING IN CLASSES**: Must be **up to date on COVID-19 vaccination**: Up to date means you have received all CDC recommended COVID-19 vaccines, including any booster dose(s) when eligible. Dose Date:_____/_____/_____(MM/DD/YR) Dose Date:_____/_____/_____(MM/DD/YR) Dose Date:_____/_____/_____(MM/DD/YR)
Annual Influenza vaccine	**MUST BE GIVEN AFTER AUGUST OF ENTERING YEAR** Dose Date:_____/_____/_____(MM/DD/YR)
Tdap Vaccine • Tetanus/Diphtheria WITH Pertussis (whooping cough) **(Please note: The requirement is Tdap and not Td or Dtap)**	**ONE DOSE ON OR AFTER AGE 7YRS FOR NON-Healthcare Professional Students** **- OR -** **ONE DOSE IN THE LAST 10YRS required for Healthcare Professional Students** Dose Date:_____/_____/_____ (MM/DD/YR)
MMR Vaccine • Measles, Mumps & Rubella	**YOU MUST HAVE 2 DOSES. THE FIRST DOSE MUST BE *ON OR AFTER YOUR FIRST BIRTHDAY*.** Dose 1 Date:_____/_____/_____ **(must be on or after your 1st birthday)** **(Dose 1 & 2 must be AT LEAST 28 days apart)** Dose 2 Date:_____/_____/_____ **IF UNABLE TO OBTAIN PROOF OF VACCINATION YOU MUST OBTAIN A BLOOD TITER TEST.** *** ATTACH A COPY OF YOUR LAB REPORT.** **POSITIVE Measles IgG Antibody Titer** Titer Date:_____/_____/_____ **POSTIVE Mumps IgG Antibody Titer** Titer Date:_____/_____/_____ **POSITIVE Rubella IgG Antibody Titer** Titer Date:_____/_____/_____ • If you have a negative or indeterminate titer, obtain one dose of MMR and repeat titer 4 weeks later. If titer is still negative, receive a 2nd dose of MMR.
Varicella (Chicken Pox) Vaccine	**YOU MUST HAVE 2 DOSES. THE FIRST DOSE MUST BE *ON OR AFTER YOUR FIRST BIRTHDAY*.** Dose 1 Date:_____/_____/_____ **(must be on or after your 1st birthday)** **(Dose 1 & 2 must be AT LEAST 28 days apart)** Dose 2 Date:_____/_____/_____(MM/DD/YR) **IF YOU HAD THE DISEASE AS A CHILD OR IF YOU ARE UNABLE TO OBTAIN PROOF OF VACCINATION, YOU MUST OBTAIN A BLOOD TITER TEST.** **POSITIVE Varicella IgG Antibody Titer** Titer Date:_____/_____/____(MM/DD/YR) • If you have a negative or indeterminate titer, obtain one dose of varicella vaccine and repeat titer 4 weeks later. If titer is still negative, receive a 2nd dose of varicella.

Meningococcal Vaccine • MCV4 (Menactra or Menveo preferred) for students 21 yrs or younger	**THE MOST RECENT DOSE MUST BE *ON OR AFTER YOUR 16TH BIRTHDAY.*** Dose Date:_____/ ___/_____(MM/DD/YR)

ADDITIONAL REQUIREMENTS FOR ALL HEALTHCARE PROFESSIONAL SCHOOL STUDENTS (MEDICAL/NURSING/DENTAL/SOCIAL WELFARE)	
Hepatitis B Immunity All students must have a series of three Hepatitis B vaccinations (initial dose, dose two at 1 month, and dose three at 6 months). A post-vaccine surface antibody titer (to demonstrate immunity) is **required** one month after 3rd vaccine dose.	Dose #1_____/____/_____(MM/DD/YR) Dose #2____/_____/_____ (MM/DD/YR) Dose #3____ / _____/ _____ (MM/DD/YR) **Hep B surface antibody titer**: Reactive: ☐ Non-Reactive: ☐ Date:_____/_____/_____ *If antibody non-reactive, Hepatitis B surface antigen is required prior to repeat series. **Hep B surface antigen titer**: Reactive: ☐ Non-Reactive: ☐ Date:_____/_____/_____ If Hep B surface antigen is negative, get Hepatitis B vaccine booster. Repeat titer one month later. Dose #4_____/_____/_____(MM/DD/YR) 2nd Hep B surface antibody titer: Reactive: ☐ Non-Reactive: ☐ Date:_____/_____/_____ *If repeat Hep B surface antibody is non-reactive, continue with 2nd series and then check titer one month later. Dose #5_____/_____/_____ (MM/DD/YR) Dose #6___/_____/_____(MM/DD/YR) 3rd Hep B surface antibody titer: Reactive: ☐ Non-Reactive: ☐ Date:_____/_____/_____ *If repeat Hep B surface antibody is non-reactive, please schedule with an Ashe Center clinician to discuss.

STRONGLY RECOMMENDED IMMUNIZATIONS	***NOTE: These vaccinations are recommended BUT NOT required to be compliant with enrollment**
HPV Vaccine • Human Papilloma Virus Vaccine • 3 dose series	**RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26** **HPV 4** Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____ **OR** **RECOMMENDED FOR ALL STUDENTS (ALL GENDERS) UP TO THE AGE OF 26** **HPV 9** Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____
Meningococcal B Vaccine • Trumemba or Bexsero	**RECOMMENDED FOR AGES 16 – 23YRS AFTER DISCUSSION WITH A HEALTHCARE PROVIDER** Dose 1 Date: _____ Dose 2 Date: _____ **(Trumemba is either a 2 dose or 3 dose series. Bexsero is a 2 dose series)** Dose 3 Date: _____

Hepatitis A Vaccine • 2 dose series	Dose 1 Date: _____ **(Dose 2 must be at LEAST 6 mths following first)** Dose 2 Date: _____
Polio Vaccine • 4 dose series	Dose 1 Date: _____ Dose 2 Date: _____ Dose 3 Date: _____ Dose 4 Date: _____
Pneumococcal Vaccine • PCV13 +/or PPSV23 based on health history	Dose PCV13 Date: _____ Dose PPSV23 Date: _____ • Only recommended for those with a history of asthma, diabetes, smokers and those with immunosuppression due to illness or medication after discussion with your healthcare provider

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE

Provider's Signature:_____Practice Stamp:

Provider's Name:_____Date: _____
(Physician/PA/NP/RN)