



Tuberculosis (TB) Screening Documentation Form

To return form, student must log in at <http://studenthealthportal.brown.edu/> and upload.

Section 1 – Student Information

Name: _____ **Date of Birth:** _____
Last First Middle mm / dd / yyyy

Address: _____
Street City State Zip Code Country

Section 2 – TB (Tuberculin) Skin Test

Date TB skin test given: _____ Date TB skin test read (must be read in 48-72 hours): _____

Results (must be recorded in mm of induration; if no induration, write “0”): _____ **mm**

Section 3 – IGRA (QuantiFERON Gold, T-SPOT)

Date of test: _____ **Test:** QuantiFERON Gold T-SPOT

Result: Positive Negative Indeterminate

Section 4 – Chest X-ray (Required if tuberculosis test is positive)

Date: _____ **Result:** Normal Abnormal

Dates of Treatment for latent or active TB: _____

Treatment Medication: _____

Section 5 – Signatures

Signature of Physician / Medical Provider: _____ **Date:** _____

Physician / Medical Provider name (please print/clinic stamp): _____

Address: _____

Phone: _____ Fax: _____