**RETURNING STUDENT IMMUNIZATION/HEALTH RECORD FOR TB**

**SUBMISSION OF THIS FORM IS MANDATORY IF THE RESULTS OF LAST YEAR’S TB TEST WAS NEGATIVE.**  
(If your TB test result from the last academic year was Positive, further testing is not required.)

<table>
<thead>
<tr>
<th>Student Name: ________________________</th>
<th>Student ID #: _______________</th>
<th>Program: ____________</th>
</tr>
</thead>
</table>

<table>
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<tr>
<th>Student Email: ______________________</th>
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* Note: Students are encouraged to keep their personal health information confidential. We do not request students to submit their health information via email as we cannot ensure security from your home to the university.

**DATE OF TUBERCULIN TEST:** ________________  
**Results:** Negative ☐  Positive ☐ 

Reading (induration) in mm.__________

Date of last known negative: ________________  
Previous treatment for TB: No ☐ Yes ☐

**CHEST X-RAY (**required if test was positive):**

| X-Ray Date: ________________ | Results: ________________  
(normal or abnormal) |
|-----------------------------|------------------------|

Chest X-rays should be taken on students who:

i. are TB skin test positive and have never been evaluated for the positive skin test;

ii. had a previous diagnosis of tuberculosis but have never received adequate treatment for TB; and/or

iii. have pulmonary symptoms that may be due to TB.

If the evaluation of a student is suggestive of TB, the health care provider MUST direct the student to a TB clinic for further assessment and recommendations. (For example: Toronto Western Hospital TB Clinic Tel: 416-603-5853). Active cases of TB, those suspected of having active TB disease, tuberculin skin test converters and those with a positive TB skin test are reportable to the local Medical Officer of Health. Occupationally acquired active TB and LTBI are also reportable to Workplace Safety and Insurance Board (WSIB) and the Ontario Ministry of Labour.

**STUDENT AUTHORIZATION (To be completed by the student):**

<table>
<thead>
<tr>
<th>Student Name: __________________________________________</th>
<th>Student ID #: ____________________</th>
</tr>
</thead>
</table>

I authorize the health professional listed below to complete the immunization record. I give my consent that the information on this form may be shared with university/clinical teaching site and University of Toronto employees as appropriate. If I choose to submit my health information via email, I accept that they may not be secure.

Signature of Student: _________________________________  
Date: ___________________

**HEALTH CARE PROVIDER AUTHORIZATION (To be completed by a health care professional; students cannot complete their own forms):**

I have read and understood the requirements as instructed. I certify that the above information is complete and accurate.

Signature of health care professional: ___________________________  
Date: ___________________  
STAMP

or Name, address, and phone number of clinic/health care centre/hospital where form was complete