Tuberculosis Clearance Form

This satisfies requirements in the California Education Code, and the California Health and Safety Code.

Certificate of Completion of Tuberculosis Risk Assessment and/or Examination

Date of TB risk assessment and/or examination: _____month/____day/_____year

First and Last Name of the patient assessed and/or examined: _____

Date of Birth: _____month/____day/_____year

The patient named above has submitted to a pediatric tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has had a TB skin test (TST) or TB blood test (IGRA), and chest x-ray (CXR) if indicated, and upon exam determined to be free of infectious tuberculosis. The patient is cleared to attend school.

Please print, place label or stamp with Health Care Provider information below:

_____

Name of Health Care Provider Completing the TB Risk Assessment and/or Examination

_____

Health Care Provider Signature

_____

Facility Name and Address

In order to protect the privacy of individuals, all information regarding this assessment is considered confidential. The facility and the Los Angeles County Department of Public Health cannot release the name(s) of any ill person(s).

County of Los Angeles Public Health