Welcome to Moore College of Art & Design. I am Diane Azuma, the Director of Health Services. Health Services is located on the first floor of Stahl Hall. I am here during the fall and spring semesters to meet students’ routine health care needs and to handle emergencies. My hours are Monday through Friday from 9a.m. - 3p.m.

In addition, the College refers students to area physician practices (please see below for further information). Office visits and diagnostic tests are billed to the students’ insurance. If a student needs a specialist, I can also handle some referrals. In addition to this coverage for your physical needs, we have in Student Services a wonderful College Counselor, Ruth Gayle, M.Ed., who has been working with artists here at Moore for over 15 years and who is well respected by students, faculty and staff.

The College requires that students have health insurance. Many of our students are already insured under their family’s health insurance plan. Those students will need to submit documentation of coverage. All others must purchase the school's health insurance. Further details can be found in the following section.

I am enclosing a health form; it is the student's responsibility to have this form completed, signed by their physician, and returned to the Health Services Office. This form is kept in a confidential file in Health Services so that I can better serve your needs.

The health form, including a copy front and back of your health insurance card and immunization record signed by your physician, **must be completed and returned to the school by the start of classes. A completed health form is required for both commuters and residents. Residents without completed health forms may not move into housing.** To assist in making your transition to college smoother, we have some suggestions for you. Plan ahead! At this time of the year, it is difficult to get a timely appointment with your physician due to the increased demand of students needing physicals for school. Secondly, know what your health insurance is, have the card with you, and find out how to use it. Thirdly, if you are being treated for any long term medical or psychological conditions and you will be far away from home, we suggest that you discuss with your physician and/or therapist about making connections to physicians or therapists near school to ensure continuity of care while you are at school.

If you do not have a physician to complete this form, you may make an appointment at the following offices. You should make this appointment prior to the deadline for return of the health form. There is a fee for this visit in addition to the charge for vaccinations or laboratory work you may require. All charges for this appointment are the responsibility of the student. Please verify if your present health insurance is accepted at these offices. **You must bring previous vaccination records.**

Drexel Family Medicine @ Center City - Dr. Annette Gadegbeku  
219 N. Broad St. 6th Floor  Philadelphia, PA 19107 Tel # 215-482-1234

PENN CARE @ Rittenhouse- Dr. Elizaveta Tikhonova  
1840 South St. Philadelphia, PA 19146 Tel # 215-893-6200

Because the College must have your health form to properly address your medical needs, **failure to return a completed health form by September 11, 2014 will result in a $100 penalty, and a hold will be placed on your student account.**

I am pleased to say that the College is well equipped to meet your health needs. There are no long waits or anonymity often associated with university health services. I welcome you as an incoming student, and I look forward to helping you stay healthy while you pursue your education as an artist.

Diane Azuma, RN  |  Director of Student Health Services  
20th Street and The Parkway, Philadelphia, PA 19103  
tel 215.965.4032  |  fax 215.564.1459  
dazuma@moore.edu  |  www.moore.edu
HEALTH SERVICES (ext.4032)

A health history must be completed by ALL students. This information is strictly for the use of the Student Health Services and will not be released to anyone without your knowledge or consent. **PLEASE COMPLETE AND RETURN DIRECTLY TO THE DIRECTOR OF HEALTH SERVICES.**

<table>
<thead>
<tr>
<th>Last name</th>
<th>First</th>
<th>Middle</th>
<th>Social Security Number</th>
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<table>
<thead>
<tr>
<th>Home address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<table>
<thead>
<tr>
<th>Local address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<table>
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<tr>
<th>Cell phone #</th>
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<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Marital Status</th>
<th>Class Entering</th>
<th>Home Telephone</th>
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<td></td>
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<table>
<thead>
<tr>
<th>Next of Kin's name</th>
<th>(relationship)</th>
<th>Home Telephone</th>
<th>Business Telephone</th>
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<tbody>
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**HEALTH INSURANCE INFORMATION:**
**PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARDS**

**PERSONAL HISTORY:** Please answer all questions

<table>
<thead>
<tr>
<th>Gastrointestinal:</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent diarrhea</td>
<td></td>
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</tr>
<tr>
<td>Hemorrhoids</td>
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<td></td>
</tr>
<tr>
<td>Ulcer</td>
<td></td>
<td></td>
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<tr>
<td>Frequent upset stomach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heartburn</td>
<td></td>
<td></td>
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<tr>
<td>Irritable bowel</td>
<td></td>
<td></td>
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<tr>
<td>Jaundice</td>
<td></td>
<td></td>
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<tr>
<td>Gall bladder problem</td>
<td></td>
<td></td>
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<tr>
<td>Hernia</td>
<td></td>
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<tr>
<td>Other:</td>
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<table>
<thead>
<tr>
<th>Genitourinary:</th>
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<tr>
<td>Kidney disease</td>
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<td>Bladder/kidney infections</td>
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<td>Kidney stones</td>
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<tr>
<td>Sexually transmitted infection</td>
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<tr>
<td>No period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Painful periods</td>
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<td></td>
</tr>
<tr>
<td>Irregular periods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast lump</td>
<td></td>
<td></td>
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<tr>
<td>Pelvic infection</td>
<td></td>
<td></td>
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<tr>
<td>Pregnancies</td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
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<table>
<thead>
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<th>Musculoskeletal:</th>
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<td>Back problems</td>
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<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strains/sprains</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck injury</td>
<td></td>
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<tr>
<td>Other:</td>
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<table>
<thead>
<tr>
<th>Skin:</th>
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<th>No</th>
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<tbody>
<tr>
<td>Acne</td>
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<tr>
<td>Eczema</td>
<td></td>
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<tr>
<td>Psoriasis</td>
<td></td>
<td></td>
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<tr>
<td>Rashes</td>
<td></td>
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<tr>
<td>Other:</td>
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<table>
<thead>
<tr>
<th>Head:</th>
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<th>No</th>
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</thead>
<tbody>
<tr>
<td>Eye problems</td>
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<td></td>
</tr>
<tr>
<td>Glasses/Contacts</td>
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<tr>
<td>Ear infections</td>
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<tr>
<td>Hearing difficulty</td>
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<tr>
<td>Nose problems</td>
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<td></td>
</tr>
<tr>
<td>Sinusitis</td>
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<td></td>
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<tr>
<td>Throat problem</td>
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<tr>
<td>Other:</td>
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<table>
<thead>
<tr>
<th>Cardiovascular:</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Murmur</td>
<td></td>
<td></td>
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<tr>
<td>High or low blood pressure</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory:</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Asthma</td>
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<td></td>
</tr>
<tr>
<td>Bronchitis</td>
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<td></td>
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<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
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<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
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<table>
<thead>
<tr>
<th>Neurological:</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Headache</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness/fainting</td>
<td></td>
<td></td>
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<tr>
<td>Seizures</td>
<td></td>
<td></td>
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<tr>
<td>Weakness</td>
<td></td>
<td></td>
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<tr>
<td>Head injury/concussion</td>
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<tr>
<td>Paralysis</td>
<td></td>
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<tr>
<td>Loss of consciousness</td>
<td></td>
<td></td>
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<tr>
<td>Frequent anxiety</td>
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</tbody>
</table>
### Frequent depression
- Yes
- No

### Worry/nervousness
- Yes
- No

### Other:
- Yes
- No

### Metabolic/Endocrine:
- Yes
- No

#### Diabetes
- Yes
- No

#### Thyroid disorder
- Yes
- No

#### Other:
- Yes
- No

#### Cancer
- Yes
- No

#### Anorexia / bulimia
- Yes
- No

### Radiation/chemotherapy
- Yes
- No

### Recent weight gain/loss
- Yes
- No

### Do you drink alcohol?
- Yes
- No

### Do you smoke?
- Yes
- No

### Infectious Illnesses:
- Yes
- No

#### Chicken pox
- Yes
- No

#### Measles
- Yes
- No

#### Rubella-German measles
- Yes
- No

### Do you take any medications? (ie: all drugs, including over the counter drugs, birth control pills, laxatives, sleeping medications, etc.)
- Yes
- No

If yes, please list: __________________________________________________________________________

### Please list Physician(s), Dentist, Opthamologist
- Yes
- No

### Telephone number
- Yes
- No

### Are you allergic to any medications?
- Yes
- No

### Allergies (Food, insects, others)
- Yes
- No

### Have you had difficulty with school studies or teachers?
- Yes
- No

### Have you had an illness or injury or been hospitalized other than already noted?
- Yes
- No

### Have you received treatment or counseling for stress, nervous condition, personality or character disorder, or emotional problem?
- Yes
- No

### FAMILY HISTORY

<table>
<thead>
<tr>
<th>Parents</th>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Age of Death</th>
<th>Cause of Death</th>
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</table>

Number of brothers________ sisters________

### HAVE ANY OF YOUR BLOOD RELATIVES EVER HAD ANY OF THE FOLLOWING?

<table>
<thead>
<tr>
<th>Tuberculosis</th>
<th>Diabetes</th>
<th>Kidney disease</th>
<th>Arthritis</th>
<th>Stomach disease</th>
<th>Asthma</th>
<th>Bleeding disorder</th>
<th>Hay fever</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Relationship</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Epilepsy</td>
<td>Convulsions</td>
<td>Cancer</td>
<td>High blood pressure</td>
<td>Stroke</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Suicide</td>
</tr>
</tbody>
</table>

### The information on this form is accurate and complete to the best of my knowledge.
Signature__________________________ Date________________

Signature of parent/guardian if student is a minor ______________________ Date________________

### PARENTAL PERMIT

The Law requires that parental permission be obtained for procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out with no unnecessary delays. However, no major operation will be performed, except in extreme emergency, without parents being contacted and fully informed. I give permission for such diagnostic and therapeutic procedure as may be deemed necessary for my daughter and also to present information concerning her medical condition to other responsible college officials when deemed desirable.

Signature________________________________________ Relationship____________________ Date____________
**Immunization Record**

**Part I**

Name  
Last Name  
First Name  

Address  
Street  
City  
State  
Zip  

Date of Entry  
Date of Birth  
School ID#  

Mo  Yr  
Mo  Day  Yr  

Part-time  
Full-time  
Undergraduate  
Post-bacc  
Commuter  
Resident  

**Part II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.**  
*All information must be in English.*

Height:  
Weight:  

**A. M.M.R. (Measles, Mumps, Rubella)**  
(Two doses required at least 28 days apart for students born after 1956.)

1. Dose 1 given at age 12 months or later  
2. Dose 2 given at least 28 days after first dose  

**B. Polio**  
(Primary series, doses at least 28 days apart. Three primary series are acceptable. Refer to ACIP website for details.)

1. OPV alone (oral Sabin three doses)  
2. IPV/OPV sequential  
3. IPV alone (injected Salk four doses)  

**C. Varicella**  
(Birth in the US before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement)

1. History of Disease  
2. Varicella antibody  
3. Immunization  
a. Dose #1  
b. Dose #2, given at least 12 weeks after first dose 1-12 years and at least 4 weeks after the first dose if age 13 years or older  

**D. Tetanus-Diphtheria-Pertussis**

1. Primary series completed?  
   Date of last dose in series:  
2. Date of most recent booster dose:  
   Type of Booster:  
   Tdap Booster recommended for ages 11-64 unless contraindicated.  
* Students must have proof of Tdap (Tetanus, Diphtheria and Pertussis vaccine) immunization.  
Students with Td (Tetanus, Diphtheria) only will not be considered compliant.
Immunization Record

Last Name ______________________________ First Name ______________________ DOB ________________

E. Hepatitis A

1. Immunization (Hepatitis A)
   a. Dose #1 _____/_____/______
   b. Dose #2 _____/_____/______

2. Immunization (Combined Hepatitis A and B Vaccine)
   a. Dose #1 _____/_____/______
   b. Dose #2 _____/_____/______
   c. Dose #3 _____/_____/______

F. Hepatitis B (ALL COLLEGE STUDENTS- Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody meets the requirement.)

1. Immunization (Hepatitis B)
   a. Dose #1 _____/_____/______
   b. Dose #2 _____/_____/______
   c. Dose #3 _____/_____/______

   Adult form ___ Child form ___

2. Immunization (Combined Hepatitis A and B Vaccine)
   a. Dose #1 _____/_____/______
   b. Dose #2 _____/_____/______
   c. Dose #3 _____/_____/______

3. Hepatitis B surface antibody Date _____/_____/______ Result: Reactive _____ Non-reactive _____

G. Meningococcal Quadrivalent (A, C, Y, W-135) One or Two doses for all college students – revaccinate every 5 years if increased risk continues.

Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible):

   Dose #1 _____/_____/______
   Dose #2 _____/_____/______

Quadrivalent polysaccharide (acceptable alternative if conjugate not Available):

   Date _____/_____/______
   Date _____/_____/______

H. Pneumococcal Polysaccharide Vaccine (One dose for members of high-risk groups) Date: _____/_____/______

I. Influenza
   Date of last dose: _____/_____/______
   Trivalent inactivated influenza vaccine (TIV) _____ Live attenuated influenza vaccine (LAIV) _____

J. Quadrivalent Human Papillomavirus Vaccine (HPV2 or HPV4)
   (Three doses of vaccine for females and males11-26 years of age at 0, 2, and 6 month intervals.)

   Immunization (indicate which preparation) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____
   a. Dose #1 _____/_____ Mo/ Yr
   b. Dose #2 _____/_____ Mo/ Yr
   c. Dose #3 _____/_____ Mo/ Yr
Immunization Record

Last Name ______________________________ First Name ______________________ DOB ________________

K. TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? □ Yes □ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? □ Yes □ No

(If yes, please CIRCLE the country, below)

Afghanistan    Ecuador    Maldives    Senegal
Algeria        El Salvador  Mali      Serbia
Angola         Equatorial Guinea Marshall Islands Seychelles
Argentina      Eritrea     Mauritania Sierra Leone
Armenia        Estonia     Mauritius Singapore
Azerbaijan     Ethiopia    Mexico     Solomon Islands
Bahrain        Fiji       Micronesia (Federated States of) Somalia
Bangladesh     Gabon       Mongolia South Africa
Belarus        Gambia      Morocco South Sudan
Belize         Georgia     Mozambique Sri Lanka
Benin          Ghana       Myanmar Sudan
Bhutan         Guatemala  Namibia    Suriname
Bolivia (Plurinational State of)    Guinea Nauru Swaziland
Bosnia and Herzegovina    Guinea-Bissau Nepal Tajikistan
Botswana       Guyana     Nicaragua Thailand
Brazil         Haiti       Niger      Timor-Leste
Brunei Darussalam    Honduras Nigeria   Togo
Bulgaria        India      Niue      Trinidad and Tobago
Burkina Faso    Indonesia  Pakistan Tunisia
Burundi        Iran (Islamic Republic of) Palau Turkey
Cabo Verde      Iraq       Panama Turkmenistan
Cambodia       Kazakhstan Papua New Guinea Tuvalu
Cameroon       Kenya      Peru       Uganda
Central African Republic    Kiribati Philippines United Republic of
 Chad           Kuwait     Poland Tanzania
China          Kyrgyzstan Portugal Uruguay
Colombia       Lao People's Democratic Republic Qatar Uzbekistan
Comoros        Republic  Republic of Korea Vanuatu
Congo          Latvia     Republic of Moldova Venezuela (Bolivarian
Côte d'Ivoire   Lesotho     Republic of Russia Federation Repub of)
Democratic People's Republic of Korea    Liberia Romania Repub of
Democratic Republic of the Congo    Libya Russian Federation Viet Nam
Djibouti       Malawi     Rwanda    Yemen
Dominican Republic    Madagascar Saint Vincent and the Grenadines Zimabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of >20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodada

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? □ Yes □ No

(If yes, CHECK the countries, above)

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? □ Yes □ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? □ Yes □ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease. – medically underserved, low-income, or abusing drugs or alcohol? □ Yes □ No

If the answer is YES to any of the above questions, Moore College of Art & Design requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.
Immunization Record

Last Name ____________________________ First Name ______________________ DOB __________________

TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by health care provider) Clinicians should review and verify the information above. Persons answering YES to any of the questions in Part K are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes _____ No _____

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes _____ No _____

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____

If No, proceed to 2 or 3

If yes, check below:
- Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)

Date Given: ____/____/____   Date Read: ____/____/____
M      D       Y             M      D       Y
Result: ________ mm of induration   **Interpretation:   positive____ negative____

Date Given: ____/____/____   Date Read: ____/____/____
M      D       Y                         M      D       Y
Result: ________ mm of induration   **Interpretation:   positive____ negative____

**Interpretation guidelines

An induration of 5 or more millimeters is positive:
- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 mo.)
- HIV-infected persons

An induration of 10 or more millimeters is positive:
- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

An induration of 15 or more millimeters is positive:
- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method)   QFT-GIT    T-Spot    other____
M      D       Y
Result: negative____  positive____  indeterminate____  borderline____ (T-Spot only)

Date Obtained: ____/____/____ (specify method)   QFT-GIT    T-Spot    other____
M      D       Y
Result: negative____  positive____  indeterminate____  borderline____ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____   Result: normal____ abnormal____
M      D       Y
Management of Positive TST or IGRA
All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with *M. tuberculosis* (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunoileal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol

- Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

______ Student agrees to receive treatment

______ Student declines treatment at this time

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HEALTH CARE PROVIDER

Name ________________________________

Address ________________________________

Phone ________________________________

Physician's Signature ________________________________

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Please return completed forms to: Moore College of Art & Design
Health Services Office
20th Street and The Parkway
Philadelphia, PA 19103
215.965.4032
215.564.1459 (fax)