NWACC STUDENT RECORDS
NORTHWEST ARKANSAS COMMUNITY COLLEGE
Maximize Potential. Exceed Expectations.

Rules and Regulations Pertaining to Tuberculosis Screening for Foreign-Born College Students

•Any person born in a country where TB is endemic, who is not a permanent resident and receives instruction in a room in which other students are present, are required to undergo TB screening and submit those results to the NWACC Student Records Office. This applies to both part-time and full-time students.

•TB is not endemic in the countries listed below and students from these countries are **not included:**

American Region:

Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, and Virgin Islands (USA)

European Region:

Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, and United Kingdom

Western Pacific Region:

American Samoa, Australia, and New Zealand

•Acceptable Tuberculin Tests

- **•Tuberculin Skin Test (TST) in mm**
- **•Interferon Gamma Release Assay (IGRA)**

•Students with a documented tuberculin skin test reaction of 10 mm or more or a positive interferon-gamma release assay (IGRA) must have a radiograph interpreted by a physician associated with the Health Department, a board eligible radiologist, pulmonologist, or infectious disease specialist.

•Students who have had the required screening performed in the United States or Canada within the six months prior to enrollment will not be required to have it repeated, provided they present the satisfactory documentation. Documentation must include: Name and address of provider, date applied, result of TST in mm of induration or of interferon-gamma release assay (IGRA), Date TST read or interval between application and reading, and signature of provided.

•Students are required to comply within 45 days of enrollment. No student who is not fully in compliance with the requirements of this regulation shall be permitted to enroll for a subsequent semester or term, to have credits transferred, or to graduate until he/she is fully compliant.

MedExpress
1900 W Walnut St
Rogers, AR 72756
479-636-1337

MedExpress
2890 N College Ave
Fayetteville, AR 72703
479-582-1279

TUBERCULIN SKIN TESTING FOR COLLEGE STUDENTS
Arkansas Department of Health – Required Information
ALL SECTIONS OF THIS FORM MUST BE COMPLETED

Last Name: _____ **First Name**: _____ **MI**: _____

Student ID#:_____ **Date of Birth**: _____ **Age**: _____

Social Security #:_____ **Enrollment Date**: _____ **Gender**: Male Female

Race: Non-Hispanic White White Hispanic Non-Hispanic Black Black Hispanic
Asian Pacific Islander American Indian Other

What Country were you born in? _____

Have you been out of the US in the last 5 years? Yes No

Most recent year of travel? (19 - -) _____

Have you been to: Africa Asia South America Eastern Europe or Other? _____

BCG? Yes No or Unknown

Have you had an HIV test? Yes No **Date (19 - -)**: _____ **Result**? Positive or Negative

Previous TST? Yes No **Reading of TST**? **(mo.)**:_____ **Date (19 - -)**:_____

If reading is unknown, was it read as positive or negative? Positive Negative

Location: _____

Record of Current Tuberculin Skin Test (TST) (Attach documentation)

Tuberculin Antigen Used: Tubersol Aplisol Unknown

Date of 1st TST: _____ **Reading (mm)**:_____ **Date Read**: _____ **Location**: _____

Date of 2nd TST: _____ **Reading (mm)**:_____ **Date Read**: _____ **Location**: _____

Date of 3rd TST: _____ **Reading (mm)**:_____ **Date Read**: _____ **Location**: _____

Record of Current Chest Radiograph

Chest Radiograph? Yes No **Date (mo./day/19 - -)**:_____

Provider: _____ **Test Results**_____

Location: _____

Treatment Recommended: Yes No

ARKANSAS CERTIFICATION OF TUBERCULOSIS SCREENING FOR INSTITUTIONS OF HIGHER EDUCATION

CLINICAL ASSESSMENT BY HEALTH CARE PROVIDER

NAME OF STUDENT_____

BIRTH DATE_____**SSN**_____

EDUCATIONAL INSTITUTION_____

Please complete Box #1 or #2 and #3 if needed based on test results.

1. I certify that a **5 TU Mantoux PPD skin test** was applied on _____ and was read on _____by me or a licensed nurse under my supervision.
(mo./day/yr.)

The reading was _____ mm induration.

Name: _____ M.D. D.O. RN/RN/LPN
First MI Last
PHN School Nurse

Address: _____
Street Address or P.O. Box

_____
City State Zip Code

Signature: _____

2. **Interferon Gamma Release Assay (IGRA)**

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot Other_____

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Name: _____ M.D. D.O. RN/RN/LPN
First MI Last
PHN School Nurse

Location: _____

Signature: _____

3. I certify that an **Antero-Posterior Erect Chest Radiograph** was made on _____
And that it revealed:

- ❑ No evidence of tuberculosis, with the exception of calcified lymph nodes and/or nodules.
- ❑ Abnormalities consistent with scarring due to inactive tuberculosis.
- ❑ Abnormalities consistent with active tuberculosis.
- ❑ If certifier is the same as above, he may check here and omit name and address below.

Name: _____ M.D. D.O.

Address: _____ Medical Specialty: Radiology Pulmonology

Signature_____

Treatment Recommended: Yes No