Tuberculosis (肺結核/결핵/đèn lao/結核/별 무임) Testing Requirement

Tuberculosis screening is required of all incoming international students. This testing must be completed upon your arrival at OSU. This test is performed at the OSU Health Services building, 1202 W. Farm Road between 8 AM and 3 PM. At that time a blood sample will be drawn from your arm to be tested for tuberculosis. This test does not require a second visit unless your result indicates that you have or have been exposed to tuberculosis. It is a more accurate and reliable method of testing for tuberculosis than a skin test. Please complete this form and bring to the health center. This is a mandatory health screening and if you do not complete this during orientation your enrollment will be cancelled.

Your cost for this blood test is $53.00. This will be charged to your Bursar account.

If you have had a blood test for tuberculosis performed in the U.S. during the prior six months bring copies of that test with you. A copy of an Xray will not substitute for this blood test.

Screening information for prior Tuberculosis testing:

- Have you had a blood test for Tuberculosis (T-Spot or QuantiFERON-TB Gold) in the U.S. during the prior six months?  
  Yes  No

- Have you ever been diagnosed with active tuberculosis?  
  Yes  No

Screen information for T-Spot Collection:

In the past 4 weeks have you had any of these live-virus vaccines?

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Chinese</th>
<th>Korean</th>
<th>Vietnamese</th>
<th>Japanese</th>
<th>Arabic</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (measles, mumps, rubella)</td>
<td>麻疹・腮腺炎・風疹</td>
<td>홍역, 유형성이하선염,품진</td>
<td>Sốt, quai bì, rubella</td>
<td>はしか・おたふく風・風疹</td>
<td>الحصبة والكلاف والحصبة الألمانية</td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>水痘</td>
<td>수두</td>
<td>bính thầy dâu</td>
<td>水痘</td>
<td>الحمام</td>
</tr>
<tr>
<td>Yellow Fever</td>
<td>黃熱病</td>
<td>황열병</td>
<td>Sốt vàng da</td>
<td>黃熱病</td>
<td>الحمى الصفراء</td>
</tr>
<tr>
<td>Zostavax (shingles)</td>
<td>带状疱疹</td>
<td>대상 포진</td>
<td>Zostavax (shingles)</td>
<td>带状疱疹</td>
<td>Zostavax (shingles)</td>
</tr>
</tbody>
</table>

Signature: __________________________ Date __________________

Print Name________________________________________ CWID____________________________

Email address:_______________________________________________

Phone number______________________________________________

Do not write below this line

Vaccine date __________________________ Return date________________________