



GARDEN CITY
COMMUNITY COLLEGE

801 Campus Drive
Garden City, Kansas 67846
(620) 276-7611
www.gcccks.edu

CERTIFICATE OF HEALTH

THIS FORM IS TO BE COMPLETED AND RETURNED TO GARDEN CITY COMMUNITY COLLEGE TO ALLOW ENROLLMENT
(Finney County students take this form to Finney Co. Health Dept. for completion.)

STUDENT INFORMATION (To be completed by student) (Please print)

Last Name: _____ First name: _____ GCCC Student ID: _____

Date of birth: _____ Phone number: _____ Address: _____

The above student has been referred for TB testing and any follow up treatment as indicated. **Upon completion of testing and appropriate treatment, as documented by health care personnel below, the student will return this form to GCCC to allow enrollment.**

Tuberculin Skin Test (TST) (Mantoux/PPD documented in millimeters of induration)

DATE GIVEN ____/____/____ GIVEN BY _____

DATE READ ____/____/____ READ BY _____

RESULT: ____ MM OF INDURATION INTERPRETATION: negative ____ positive ____

-----OR-----

Interferon Gamma Release Assay Blood Test (IGRA)

DATE OBTAINED ____/____/____ SPECIFY METHOD: ____ QT ____ OTHER

RESULT: negative ____ positive ____ intermediate ____

Signature of health care provider completing blood test _____

IF EITHER OF THE ABOVE TB TESTS ARE POSITIVE OR INDETERMINATE OR YOU HAVE HAD A PREVIOUS REACTION TO TB TESTING, YOU WILL BE REQUIRED TO OBTAIN A CHEST X-RAY.

DATE OF CHEST X-RAY: ____/____/____ RESULT: normal ____ abnormal ____

IF CHEST X-RAY RESULTS ARE ABNORMAL, FURTHER EVALUATION AND TREATMENT WILL BE REQUIRED BEFORE ENROLLMENT AT GCCC.

This box is to be completed by a **representative of Finney County Health Department**. If you have obtained testing outside of Finney County, the appropriate health care provider will complete the information below. **This completed area will allow enrollment at GCCC.**

The above individual has received all required evaluations and treatments indicated and is cleared to enroll at Garden City Community College.

SIGNATURE OF HEALTH CARE PROVIDER _____ DATE _____

PRACTICE SITE

PHONE NUMBER

It will be the student's responsibility to pay for all services not covered by insurance at the time they are received.

To the best of my knowledge, the information provided above is accurate and complete. I am aware that misrepresentation of information could result in dismissal from classes at GCCC and may jeopardize my health. I agree to complete any indicated and required evaluation and treatment to be allowed enrollment and attendance at Garden City Community College.

By signing this form, I agree to allow communication between Finney County Health Department or other health care entities outside Finney County involved in my medical care relating to the implementation of the TB Risk Assessment Law (Kansas Statute KSA 2009 Supp. 65-129) and Garden City Community College.

Student Signature _____ Date _____