BUTTE COLLEGE

Health Statement

Must be completed in English by a doctor or health practitioner. **Please type in your information, print, sign, and submit.**

Note*: If you have received the Bacillus Calmette–Guérin (BCG) vaccination you may provide proof of inoculation*.

APPLICANT NAME: _____
Last Name (Family) First Name (Given) Middle Name

Tuberculosis (TB) Skin Test Date: _____ TB Skin Test Result: ❑ Negative ❑ Positive
(month/ day/ year)

To Physician: Please comment on general physical condition of student applicant. Explain any condition that may affect travel or living in the U.S. **If TB test is positive, please explain result of follow-up chest X-ray, patient's condition and treatment**.

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BUTTE COLLEGE

Physician Certification

I certify that all statements on this form are true and complete.

_____ _____
Physician Name & Signature **Date (month/ day/ year)**