NEW STUDENTS ONLY

MEDICAL PROVIDER: Please COMPLETE and SIGN this form.

REQUIRED Tuberculosis (TB) TESTING

(Regardless of receiving a BCG Vaccine as an infant)

Student Name: _____ **Date of Birth:** _____

Has student ever had a positive tuberculosis (TB) skin test or blood test in the past? ☐ No* ☐ Yes**
*If the answer is "NO", please refer to Section A. **If the answer is "YES", please refer to Section B.

SECTION A – If you answered "NO" to the above question, a current PPD skin test is required.
Note: "Current" means within the last 12 months.

PPD Date Placed _____ Date Read _____ Results _____ mm

If the results are >10 mm of induration, it is considered POSITIVE. If it is POSITIVE, a Chest X-ray is REQUIRED. In addition to the Chest X-ray, a Quantiferon Assay is highly recommended.

Chest X-Ray Date _____ Results of Chest X-ray _____

_____

Quantiferon Assay Date _____ Results of Quantiferon Assay _____

_____

Treatment, if applicable: _____

Medication: _____

Date Started _____ Date Completed _____

➡ **X** _____ _____
SIGNATURE OF MEDICAL PROVIDER DATE

SECTION B – If you answered **"YES"** to the above question, **a current Chest X-ray is required and a Quantiferon Assay is highly recommended.**
Note: "Current" means within the last 12 months.

If student has tested positive in the past, please specify date (month and year) _____.

Chest X-Ray Date _____ Results of Chest X-ray _____

_____

Quantiferon Assay Date _____ Results of Quantiferon Assay _____

_____

Treatment, if applicable: _____

Medication: _____

Date Started _____ Date Completed _____

➡ **X** _____ _____
SIGNATURE OF MEDICAL PROVIDER DATE