Toronto Metropolitan University

School of Early Childhood Studies
Faculty of Community Services

TB Test Form

As part of the School of Early Childhood Studies' non-academic documentation for field placements, and as required by our field placement partners, students must be free of communicable diseases.

This is necessary to ensure that our students protect their own health and safety, and the health and safety of children, families, visitors, employees and other students at the placement site.

****Our placement partners determine if students meet their immunization standards and have the right to refuse students who do not meet them.** **

ALL sections of this form must be completed as outlined by a healthcare provider.

Student Name:	**TMU Student ID #:**

All students must provide **proof** of a Two [2]-Step TB Skin Test.

Check one:

☐ If the student has **never** had a Two [2]-Step TB Skin Test, a mandatory **2-Step Test** is required regardless of BCG History **(Step 2 must be completed within 6 months of the placement start date).**

☐ If the student has **proof** of a previous Two [2]-Step TB Skin Test and the results of both steps were **negative,** only complete the 1-Step TB Skin Test **(Step 1 must be completed within 6 months of the placement start date).**

TUBERCULOSIS SCREENING			
TB Skin Test Step 1	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Results (induration in mm)**
TB Skin Test Step 2	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Results (induration in mm)**
Previous 2-step TB Skin Test with negative results (if applicable)	**Date Administered (yyyy/mm/dd)**	**Date Read (yyyy/mm/dd)**	**Results (induration in mm)**

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Student Name:
TMU Student ID #:

ALL sections of this form must be completed as outlined by a healthcare provider.

If a student's result on *one* or *both* tests is positive, a chest X-ray must be completed. Documentation indicating the X-ray results and the absence of tuberculosis must be produced.

1. Does this student have signs/symptoms of active TB on physical examination? Yes ☐ No ☐
2. Chest X-ray (ATTACH report, valid every four [4] years) Yes ☐ No ☐
3. Date of assessment _____(yyyy/mm/dd)
   **note: assessment must be reviewed annually*

ADDITIONAL COMMENTS		
NAME OF HEALTH CARE PROVIDER	**SIGNATURE**	**DATE OF COMPLETION (yyyy/mm/dd)**
MEDICAL OFFICE STAMP (must be included)		