

TB Test Form

To ensure that students protect their health and safety and the health and safety of children, families, visitors, employees and other students at the placement site, students must be free of communicable diseases.

All sections must be completed as outlined by a healthcare provider. **Placement partners have the right to refuse students who do not meet their immunization standards**. If, for medical reasons, you are unable to receive a required immunization or Chest X-ray, a Statement of Medical Exemption must be completed.

Name of Student: Stu	Student ID #:
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All students must provide **proof** of a Two Consecutive Step-TB Skin Test.

Check one:

□ If the student has <u>never</u> had a Two Consecutive Step-TB Skin Test, it is mandatory that they complete a **Two Step-TB Skin Test**.

 \Box If the student has <u>proof</u> of a previous Two Consecutive Step-TB Skin Test and the results of both steps were <u>negative</u>, only complete the Step 1-TB Skin Test (Step 1 must be completed no more than 6 months prior to the placement start date).

 \Box If the student has proof of a previous Two Consecutive Step-TB Skin Test and one or both of the results were **positive**, the healthcare provider will complete an annual physical exam & answer questions 1-5 on page 2 of this form.

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	Date Administered (yyyy/mm/dd)	Date Read (yyyy/mm/dd)	Induration
TB Skin Test Step 1			
TB Skin Test Step 2	Date Administered (yyyy/mm/dd)	Date Read (yyyy/mm/dd)	Induration

Previous Two Consecutive Step TB Skin Test (if applicable)	Date Administered (yyyy/mm/dd)	Date Administered (yyyy/mm/dd)	Induration	
If a student's result on <i>one</i> or <i>both</i> tests is positive, <u>a chest X-ray must be completed</u> . Documentation indicating the X-ray results and the absence of tuberculosis <u>must</u> be produced.				
	Date Administered (yyyy/mm/dd)	Date Read (yyyy/mm/dd)	X-ray Result/ Comments	
Chest X-ray				

□ Chest X-ray (ATTACH a copy of the X-ray report, valid every four [4] years)

1.	History of disease?	Yes □	No 🗆	Date	_(yyyy/mm/dd)
2.	Prior history of BCG vaccination?	Yes □	No 🗆	Date	_(yyyy/mm/dd)
3.	Does this student have signs/symptom	ns of activ	ve TB on	physical examination?	Yes 🗆 No 🗆
4.	INH Prophylaxis?	Yes □	No 🗆	Date	_(yyyy/mm/dd)
5.	Specialist Referred?	Yes □	No 🗆	Date	_(yyyy/mm/dd)

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Medical Office Stamp			
Name of Health Care Provider	Signature	Date of Completion (yyyy/mm/dd)	