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 PPD skin test is <u>required</u> between September 1, 2018 and August 31, 2019.

PPD Date Placed _____ Date Read _____ Results _____ mm

If the results are >10 mm of induration, it is considered POSITIVE. If it is POSITIVE, a Quantiferon Assay is REQUIRED.

Quantiferon Assay Date _____ Results of Quantiferon Assay _____

_____

Follow Up Testing, if applicable (repeat Quantiferon Assay or Chest X-ray): _____

_____

Medication (if ordered): _____

Date Started _____ Date to Be Completed _____

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

SECTION B – If you answered **"YES"** to the above question, **a Quantiferon Assay is <u>required</u> between September 1, 2018 and August 31, 2019.**

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

Quantiferon Assay Date _____ Results of Quantiferon Assay _____

_____

Follow Up Testing, if applicable (repeat Quantiferon Assay or Chest X-ray): _____

_____

Medication (if ordered): _____

Date Started _____ Date to Be Completed _____

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