San Mateo Union High School District

TUBERCULOSIS CLEARANCE FORM

Student: ______________________________________ DOB: ________ Grade: _____ School: ________

Dear Parent/Guardian: Date: _____________

Your student has elected to participate in a school program which requires tuberculosis clearance as follows:

[ ] Teenage students working with preschool-aged children, for example (Child Care, nursery school programs) or elementary-aged children (School/Community Service) are required to have an **annual** tuberculosis clearance.

[ ] Teenage students working as school employees (Food Service and/or Workability), are required to have tuberculosis clearance **every four years.**

A tuberculosis clearance given within the time periods stated above **in writing by a physician,** will satisfy the requirement.

A tuberculin clearance may be obtained through your student's own physician or clinic.

PHYSICIAN'S REPORT OF TUBERCULOSIS CLEARANCE

Name: ____

Birthdate: _________________________________

TST/P.P.D. Date: ___________________________ Result: ______________________________________

X-Ray Date: _______________________________ Result: ______________________________________

QuantiFERON Date: _______________________ Result: ______________________________________

Recommendations: INH ____________________ mg/daily for 9 months.

Date Started: ______________________________ Date Completed: _____________________________

Remarks: ____

Not Valid Unless Signed, Stamped & Dated

Date form completed: __________________ **NAME:**
ADDRESS:
PHONE:

____
Signature of Physician/Clinic

PLEASE STAMP/AFFIX NAME, ADDRESS, AND CONTACT INFORMATION

Health Office review/approval ____ Date: _______________
Signature of Health Aide or Health Services

Form # 603 / 11.4.22 AH