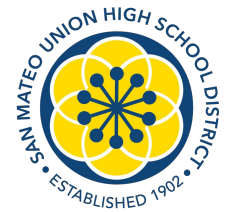


San Mateo Union High School District



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