Tuberculosis Test Form

Name _____

Last Name First Name Middle Name

Address _____

Street City State Zip Country

Date of Birth ___ / ___ / _____ **Age**_____

TO BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER. ***All information must be in English.***

TUBERCULOSIS SKIN TEST* (required of ALL fulltime Day Program Students, within 6 months of start of classes)

Date given: _____/_____/_____ Date read: _____/_____/_____ Result: _____mm induration *(if none write '0')*

NOTE: IF the tuberculosis skin test is positive, then a chest X-RAY *report* from the doctor must be attached, noting that the lungs are clear of infection.

OR

Quantiferon-TB or T-SPOT BLOOD TEST Date: _____/_____/_____ Result: _____

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone _____ Fax _____

This form or corresponding information signed by healthcare professional is required for ALL Full Time Day Program Students.