Tuberculosis Screening/Testing Form

Name: ______________________________ Date of Birth: ___/___/____

All students must complete either section A or B below. Please refer to the VCOM Immunization Policy for detailed instructions and explanation.

A. 2-Step Tuberculin Skin Test

Test 1:
Date given: ____/____/____ (Mo/Day/Yr)  Date read: ____/____/____ (Mo/Day/Yr)
Result: ________ mm  □ Positive □ Negative (Record actual mm of induration, transverse diameter; if no induration, write “0”)

*Tests must have at least 7 days but not more than 3 weeks between 1st reading and 2nd placement or the series must be repeated

Test 2:  (Must be administered at least 7 days after 1st Reading)
Date given: ____/____/____ (Mo/Day/Yr)  Date read: ____/____/____ (Mo/Day/Yr)
Result: ________ mm  □ Positive □ Negative (Record actual mm of induration, transverse diameter; if no induration, write “0”)

OR

B. Immunoassay Blood Test
Date performed: ____/____/____  Results: □ Positive □ Negative

**If TB test is POSITIVE, please proceed to sections C and D below.

C. Chest X-Ray (required ONLY if Tuberculin skin test or Immunoassay Blood Test is POSITIVE; or if history of positive PPD and/or patient is at risk of active disease.
   Result:  □ Normal □ Abnormal  Date of last chest x-ray: ____/____/____

D. Previously Treated LTBI – students previously treated for LTBI must complete the following:
Dates (i.e. length) and details (i.e. drugs, dose) of LTBI treatment regimen: ____/____/____ to ____/____/____

HEALTH CARE PROVIDER or NURSE:
Name: ___________________________ Signature: ___________________________
Address: ___________________________ Phone: ___________________________