



Patient First Name _____ Patient Last Name _____

Patient DOB _____

Patient Address _____
Street address City State Zip Code

Blood Test required if:

- _____ Student born in a High-Risk country as determined by the Health Department (see below)
- _____ Received BCG vaccine
- _____ May be done instead of skin PPD

Previously tested Positive to TB skin test:

_____ Evaluation of symptoms by MD required, documentation needed and chest x-ray within 3 years

Previous treatment received:

_____ Documentation of completion protocol needed

Mantoux (5TU tuberculin PPD)

Date Test Administered _____ **Site:** _____ Left _____ Right

Administered by _____ **Title:** _____

Date Test Read _____ **Results:** _____ **mm Induration**
(Within 48-72 hours of date administered) **Circle one:** Negative Positive Reaction

If results are positive OR greater than 10mm induration noted student must have a current Chest X-Ray to check for active TB.

Provider or Nurse Signature _____ Title _____
(Form may be signed by ONLY a nurse, APRN, or physician)

Provider or Nurse Printed Name _____ Title _____

Name of Clinic _____
Clinic Address _____
Clinic Phone # _____

Low Prevalence Countries include (low prevalence countries listed since high prevalence countries are greater in number/list):
Andora, Antigua & Barbuda, Australia, Austria, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Grenada, Iceland, Ireland, Israel (including the Occupied Palestinian Territory & E. Jerusalem), Italy, Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Liechtenstein, Luxemburg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts & Nevis, Saint Lucia, San Marino, Slovenia, Sweden, Switzerland, Trinidad & Tobago, Turks & Caicaos, United Arab Emirates, United Kingdom, United States of America, United States Virgin Islands, Vatican City.