TUBERCULIN TEST
(UPDATED ANNUALLY THROUGHOUT THE PROGRAM)

STUDENT NAME: ___________________________  STUDENT ID ____________________

PROGRAM: ________________________________________________________________

**MANTOUX TUBERCULIN SKIN TEST**
Must be within 6 months of date of program entry. Must with within 90 days of program entry for Nursing Assistant.

Date Given: _________________________________  Date Read: __________________________

Results: ________________________________________________________________

-OR-

**QUANTIFERON** (attach copy of lab results)

Date Given: _________________________________  Lab Results: __________________________

**CHEST X-RAY – Only if Test is Positive**
Attach a copy of report.

Previously positive reactors must have x-ray within 1 year of entry into program.

Results: ________________________________________________________________

**TREATMENT**

Treatment recommendations for abnormal findings: ____________________________

______________________________________________________________________________

Health Care Provider Signature: ______________________________  Date__________________

Health Care Provider Printed Name: ____________________________________________

Health Care Provider Contact Information: ______________________________________

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