West Chester University
Report of Tuberculin Skin Test
Non-Education Majors and Nursing

Section I: Demographics

_____
Last Name First M.
_____
University ID # Date of Birth
_____
Phone Number

Name of Provider Providing Service: (please print) _____

Address: _____

_____

Section II: To be completed by Health Care Provider: (See Instructions)

Tuberculosis Screening (PPD)

Date Given: _____ Time:_____

Manufacturer: _____
Lot # / Exp. date: _____
Dosage _____ Route _____
Arm: L R Signature_____

Date Read: _____ Time:_____

Result:

□ Positive _____mm
□ Negative _____mm

Signature/Title _____

Two Step Procedure (use only if required)

Date Given: _____ Time:_____

Manufacturer: _____
Lot # / Exp. date: _____
Dosage _____ Route _____
Arm: L R Signature_____

Date Read: _____ Time:_____

Result:

□ Positive _____mm
□ Negative _____mm

Signature/Title _____

Section III: If Positive: (Per CDC Guidelines)

1. **Attach copy of Chest X-ray Report _____**
2. **Is applicant free of infectious Tuberculosis Disease?**
   - ❑ **No _____**
   - ❑ **Yes**
3. **Was the applicant referred for treatment?**
   - ❑ **No**
   - ❑ **Yes if yes: When, Where and What is treatment _____**
     _____
     _____
4. **Was BCG given?**
   - ❑ **No**
   - ❑ **Yes if Yes: when_____**

Revised 3/07: RS