



TUBERCULOSIS SCREENING RECORDS

Name: _____ Date: _____

SECTION A (must be completed by those who have a history of +PPD or BCG)

Answer the following questions:

Table with 3 columns: Question, Yes, No. Contains 8 screening questions about symptoms like cough, weight loss, and chest pain.

The above health statement is accurate to the best of my knowledge. I will see my physician, and/ or health department if my health status changes.

SECTION B (CONSENT FOR PPD SKIN TEST)

I _____ consent to have a Tuberculosis skin test (PPD). I release _____ and its employees from all liability in connection with the administration and interpretation of this test.

Employee Signature: _____ Date: _____

Witness: _____ Date: _____

SECTION C (FOR ONE STEP/ANNUAL TB TESTING)

This is to certify that the above named person had a Tuberculin Skin Test placed on ____/____/____ which was read as ____mm. on ____/____/____. Site _____ - Lot _____ Exp. ____/____.

Signature MD/RN: _____ Date: _____

Address/Location: _____

SECTION D (FOR TWO STEP TB TESTING)

This is to certify that the above named person (a) had a Tuberculin Skin Test placed on ____/____/____ which was read as ____mm. on ____/____/____, _____ - Lot _____ Exp. ____/____.

and

(b) had a second Tuberculin Skin Test on ____/____/____ which was read as ____mm. on ____/____/____.

Signature MD/RN: _____ Date: _____

Address/Location: _____

SECTION E (HISTORY OF POSITIVE READING)

I have a history of a positive PPD/BCG vaccine/a PPD is contraindicated for me. Please find attached documentation of my positive PPD/BCG vaccine/ contraindication for TB testing (signed by a physician), and a copy of radiology report which shows no sign of active TB. See completed Section A documenting that I am symptom free.

Chest x-ray per CDC Guidelines: Employee to complete Section A annually. Chest x-ray does not have to be repeated unless employee becomes symptomatic or repeat chest x-ray is recommended by the MD.