



TUBERCULOSIS SCREENING

Student's Name: _____ Date of Birth: ____/____/____ Sex: F / M
Last *First* *Middle* *Month/Day/Year* *(circle)*

For Parents: Lincoln School requires students to provide evidence of being free from tuberculosis annually. Your child is due for TB screening on _____.

For health care provider: Please perform and record the results of the appropriate TB screening test(s) for this child. Contact the school nurse if you have questions regarding which test is required.

BCG vaccine <i>Not required or recommended for school age children</i> <ul style="list-style-type: none"> • <i>Date must be documented.</i> 	Date (mm/dd/yyyy): ____/____/____
TB Skin Test (Mantoux, PPD 5 TU) REQUIRED if: <ul style="list-style-type: none"> • <i>BCG more than 5 years ago, and/or</i> • <i>no history of TB disease or "positive" TB Skin Test</i> 	Date given (mm/dd/yyyy): ____/____/____ Date read (mm/dd/yyyy): ____/____/____ Result (in mm induration): _____ mm
Chest X-ray <i>Required ONLY</i> if: <ul style="list-style-type: none"> • <i>new or prior "positive" TB Skin Test, or</i> • <i>history of TB disease, or</i> • <i>indicated by current health history or exam</i> 	Date (mm/dd/yyyy): ____/____/____ Result:
Medical Examination <i>Required ONLY</i> if: <ul style="list-style-type: none"> • <i>new "positive" TB Skin Test, or</i> • <i>abnormal chest x-ray, or</i> • <i>BCG less than 5 years ago</i> 	Date (mm/dd/yyyy): ____/____/____ Result:

Name of examiner: _____ **Signature:** _____
 Address: _____ Designation: MD / MBBS / NP / PA *(circle)*
 Email: _____ Date: _____ *(mm/dd/yyyy)*