BARNARD

TUBERCULOSIS TESTING FORM

If you answered NO to ALL questions on page 5, you are NOT REQUIRED to complete this form.

This form must only be completed if you answered YES to any questions on page 5.

Section A: This section is to be completed by the student

Name: (last) (first)	
Barnard Uni:	Cell phone #:
I will reside on campus (circle one): Yes No	Date of Birth: / /

Section B: Completed by healthcare provider

Mantoux skin test

Date Placed: ☐☐☐

Date Read: ☐☐☐

_____ **mm of induration**

☐ **Negative** ☐ **Positive**

Interferon Gamma Release Assay (IGRA)

Date: ☐☐☐

☐ **Negative** ☐ **Positive**

Chest X-Ray (if tuberculosis test is positive)

Date: ☐☐☐

Interpretation: ☐ **Normal** ☐ **Abnormal**

Diagnosis

Active TB? ☐ **Yes** ☐ **No**

Latent TB? ☐ **Yes** ☐ **No**

Dates of Treatment (if any): _____

Treatment medication (if any): _____

This form must be signed, dated, and stamped by an MD, DO, NP, PA

Provider's Printed Name:

_____

Provider's Signature:

_____

Date: ☐☐☐

PROVIDER STAMP HERE:
Form not valid without provider stamp