HARRISON CENTRAL SCHOOL DISTRICT

50 Union Avenue, Harrison, New York 10528

Tuberculin Skin Testing

Patient Name: _____ Date: _____/_____/_____

The above named patient has been assessed for his/her need for formal tuberculin skin testing according to the guidelines as published by the New York State Department of Health, Center for Disease Control, and the American Academy of Pediatrics:

MUST COMPLETE EITHER SECTION A OR BE BELOW

A. PPD Test: Date Given _____/_____/_____ Date Read: _____/_____/_____

Result: _____mm induration

If Tuberculin Skin Test is Positive, now or previously, the following are required:

1. Date of Positive PPD: Date: _____/_____/_____
2. Chest X-ray: (Please attach copy of report) Date: _____/_____/_____
   - ☐ Normal
   - ☐ Abnormal _____
     (Describe)
3. Clinical Evaluation:
   - ☐ Normal
   - ☐ Abnormal _____
     (Describe)
4. Treatment:
   - ☐ No _____
     (Please explain)
   - ☐ Yes _____
     (Drug, Dose, Frequency, Dates)

B. _____ According to the guidelines, the patient does not require formal skin testing

Healthcare Provider Signature: _____ Date: _____/_____/_____

Telephone: ( ) _____ Fax: ( ) _____