



Health Services
815 North Broadway
Saratoga Springs, NY 12866
Phone: (518) 580-5550 Fax: (518) 580-5556

TUBERCULOSIS TESTING – (REQUIRED)

NAME (Please Print): _____ DOB: _____

PLEASE NOTE: A history of BCG vaccination should not preclude testing of a member of a high risk group. If there is a history of a past positive TB test, proceed to number 2.

1) Tuberculin Skin Test (PPD or Mantoux only – Required within 12 months of arrival on campus.)

Date Placed: ___/___/___ Date Read: ___/___/___
Mo Day Yr Mo Day Yr

Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0").

Interpretation (based on mm of induration as well as risk factors):

[] Positive [] Negative

2) Chest x-ray (required within 12 months of arrival on campus if TB skin test is positive):

Date of x-ray: ___/___/___
Mo Day Yr

Result: [] Normal [] Abnormal

3) Preventive or Therapeutic Tuberculosis Treatment:

Medication(s) (Please list):

_____, Dates Taken: _____
_____, Dates Taken: _____
_____, Dates Taken: _____

PROVIDER INFORMATION REQUIRED

Name/Degree/Title of Health Care Provider (Please print.) Address: (Please print or stamp.)
Provider Signature
Phone#: ()
Fax #: ()

FOR ADMINISTRATION PURPOSES ONLY

Form Complete: ___ Yes ___ No Action Needed: _____
Date Reviewed: _____ Reviewer: _____
Date of Contact: _____ Date Requested Info Received: _____ Reviewer: _____

FOR ADMINISTRATION PURPOSES ONLY

Form Complete: ____ Yes ____ No Action Needed: _____

Date Reviewed: _____ Reviewer: _____

Date of Contact: _____ Date Requested Info Received: _____ Reviewer: _____