NMH
Northfield Mount Hermon

Tuberculosis Medical Evaluation Form

This form must be completed by a healthcare provider and then uploaded via the Upload tab on the Healthcare Portal.

Student Name_____ DOB _____

Has the student ever had a **positive PPD skin test** ☐ Yes ☐ No
or received **BCG vaccine**? ☐ Yes ☐ No

If **No** to both of these questions, go to **A**.
If **Yes** to either question, skip **A** and go directly to **B**.

A: This student is **required** to have a **Mantoux/PPD skin test** within three months of arriving at NMH.

Date PPD planted: ____/____/____
Date read (must be within 48-72 hours of date planted): ____/____/____
Results in mm:_____ Interpretation: _____positive _____negative
If the PPD reading is negative, no further action is needed.
If positive, continue to **B**.

B: This student is **required** to have a **serum interferon gamma release assay (IGRA)** drawn within three months of arriving at NMH. This may be a **Tspot** or **Quantiferon** test.

Date blood drawn: ____/____/____ Quantiferon or Tspot *(circle one)*
Results: ____ positive ____ negative ____ intermediate
If result is negative, no further action is needed.
If result is positive or intermediate, continue to **C**.

C: This student is **required** to have a **chest X-ray** done within three months of arriving at NMH.

Date of chest X-ray ____/____/____ *(please attach copy of X-ray report)*
Results: ☐ Read as negative/normal: treatment for **latent TB** must be considered.
☐ Read as positive/abnormal: treatment for **active TB** must be documented below:
Drug(s): _____ Dose: _____
Dates of treatment: _____ Duration of treatment: _____

Healthcare Provider Name_____

Address _____

Phone _____Fax _____ Email _____

Healthcare Provider Signature _____

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