

## TUBERCULOSIS (TB) SKIN TESTING FORM (US/CANADIAN STUDENTS ONLY)

\*\*RISK DETERMINED BY HEALTHCARE PROVIDER USING TB ASSESSMENT FORM \*\*

Please upload completed form at [www.immunizations.health.gatech.edu](http://www.immunizations.health.gatech.edu).

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS.

Semester Beginning: \_\_\_\_\_ Country of Birth: \_\_\_\_\_  
 GT ID#: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Email: \_\_\_\_\_  
 Name (Last, First, Middle) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_  
 Zip Code: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**TUBERCULIN SKIN TEST** (Only accepted if completed in the US/Canada) TUBERCULIN SKIN TEST MUST BE COMPLETED WITHIN 6 MONTHS OF THE FIRST DAY OF CLASS.

Date placed \_\_\_\_\_ L / R Date read \_\_\_\_\_ (must be within 48 to 72 hours)  
 MMDDYY MMDDYY  
 Placed By: \_\_\_\_\_ Read By: \_\_\_\_\_  
 Lot #: \_\_\_\_\_ Exp Date: \_\_\_\_\_ Result \_\_\_\_\_ mm (record actual mm of induration, transverse  
 MMDDYY diameter. If no induration, record as "0 mm")  
 \*Declined due to QuantiFERON test completed: Date: \_\_\_\_\_ (attach the official lab report)

**FINAL INTERPRETATION**- Based on Criteria for Tuberculin Positivity below, by Risk Group ☐ **POSITIVE** ☐ **NEGATIVE**

Reaction > 5 mm of Induration	Reaction > 10mm of Induration	Reaction > 15mm of Induration
<ul style="list-style-type: none"> <li>Human immunodeficiency virus (HIV)-positive persons</li> <li>Patients with organ transplants and other immunosuppressed patients (receiving the equivalent of <math>\geq 15</math> mg/d of prednisone for 1 month or more)</li> </ul>	<ul style="list-style-type: none"> <li>Recent immigrants to the U.S. (within the last 5 years) from high prevalence countries</li> <li>Persons with silicosis, diabetes, chronic renal failure, leukemias and lymphomas, carcinoma of the head, neck and lung, weight loss of <math>\geq 10\%</math> of ideal body weight, gastrectomy, and jejunioileal bypass</li> </ul>	<ul style="list-style-type: none"> <li>Person with no risk factors for TB</li> <li>Persons who are otherwise at low risk and are tested at the start of employment, a reaction of <math>\geq 15</math> mm is considered positive</li> </ul>
<ul style="list-style-type: none"> <li>Fibrous changes on chest x-ray consistent with prior TB</li> <li>Recent contacts of infectious TB case</li> </ul>	<ul style="list-style-type: none"> <li>Residents and employees of the high risk congregate settings.</li> <li>Mycobacterial laboratory personnel</li> <li>Injecting drug users</li> <li>Children less than 5 years of age or infants, children, and adolescents exposed to adults at high-risk</li> <li>Recent conversion (increase of <math>\geq 10</math> mm of induration within the past 2 years)</li> </ul>	

**Chest X-RAY** (Required if history of positive skin test, **Chest x-ray must be completed in the US/ Canada ONLY.** Chest x-ray must be performed after the date of the positive skin testing. XRAYs MUST BE COMPLETED WITHIN 6 MONTHS OF THE FIRST DAY OF CLASS. **Upload a copy of the chest x-ray report signed by the doctor.**

Date of chest x-ray \_\_\_\_\_ Date of Positive PPD: \_\_\_\_\_ Result: ☐ **NORMAL** ☐ **ABNORMAL**  
 MMDDYY MMDYY

### **Treatment for latent TB**

INH given? ☐ YES ☐ NO Rifampin ☐ YES ☐ NO

Other Treatment: \_\_\_\_\_

Duration of Treatment: From \_\_\_\_\_ to \_\_\_\_\_  
 MMDDYY MMDDYY

### **SIGNATURE OF HEALTHCARE PROVIDER AND DATE REQUIRED**

Provider Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_\_\_

PHYSICIAN OFFICE STAMP