Southeast community college **TUBERCULOSIS SKIN TEST**

APPLICANT INFORMATION:

Name (PRINTED)______________________________ SCC ID# or SS# ______________________

Program____

■ **Initial Two-Step Tuberculosis** skin test (within last 12 months) **Day, month and year must be indicated.**

TEST #1 Date:____________________ Findings: ______________________________

TEST #2 Date:____________________ Findings: ______________________________

(The second TB Test should be completed 7-21 days after the first TB reading.)

IF YOU HAVE A **POSITIVE TUBERCULOSIS SKIN TEST,** THE FOLLOWING MUST BE COMPLETED BY A HEALTH CARE PROVIDER:

T-Spot blood test: Date: ______ / ______ / ______

Result: _______ Negative _____ Indeterminate _______ Positive

OR

Interferon Gamma Release Assay (IGRA) blood test: Date: ___ / _____ / _____

Result: _______ Negative _____ Indeterminate _______ Positive

IF THE **BLOOD WORK SHOWS POSITIVE,** THE FOLLOWING MUST BE COMPLETED BY A HEALTH CARE PROVIDER:

Chest X-ray: Date: ___ / _____ / _____ _______ Normal _______ Abnormal
(Copy of the official X-ray/lab report must be attached.)

Treatment Completed: ___ No ___ Yes

Did you receive the BCG vaccination? ___ No _____ Yes
If yes, the student ***must*** provide the Health Science Division with documentation of a negative chest x-ray.

HEALTH CARE PROVIDER INFORMATION:

Physician, Physician Asst. or Registered Nurse signature and information required; title must also be indicated. (If it is determined that provider information is falsified in any way, the student will be dismissed from the program and will not be eligible for admission to any health program at SCC.)

Name (PRINTED): ______________________________ Signature: ______________________

Clinic/Group Name: ______________________ Address: ______________________________

City: ______________________________ State: ______________ Zip: ______________

Phone Number: ______________________________ **Date form completed:** ______________