

Tuberculin Screening Record

To be filled out by student:

Name: _____
(family name) (personal name)

Birthdate: _____/_____/_____
(Month) (Date) (Year)

Social Security number: _____ - _____

Student ID number _____ (New students see Admissions letter for ID number)

To be filled out by doctor or nurse:

Instructions to the physician:

In accordance with guidelines established by the American College Health Association, the University of Minnesota **requires a mantoux (PPD) test** unless medically contraindicated.

Medical Contraindications:

Previous positive mantoux
BCG vaccine in past 5 years
Current cortisone therapy

Previous TB disease
 Live vaccine in past 6 weeks
 Current immunosuppression

Date of PPD tuberculin test within the last 12 months: _____

Date of reading: _____
(Must be 48-72 hours)

Negative: Size in mm _____
Reactive: Size in mm _____

If PPD reading is greater than 9 mm, or if mantoux test is medically contraindicated, do a chest x-ray.

Date of chest x-ray within the last 12 months: _____

Result _____

Date of completion of Isoniazid treatment: _____

(If a course of treatment has been completed, no tuberculin test or chest x-ray is necessary.)

Signature of physician or nurse or fills out this form: _____

Clinic stamp: _____

Today's date: _____

Please return to:

**Immunization Clinic
Boynton Health Service
410 Church Street SE
Minneapolis, MN 55455**