SCREENING FOR TUBERCULOSIS

Student's Name: _____ Date of Birth: ____/____/_____ Sex: F / M
Last First Middle *Month/Day/Year* *(circle)*

For the parent or guardian: Lincoln School requires students to provide evidence of being free from tuberculosis. Please contact the School Nurse if your child's medical provider has any questions regarding which test is required.

For the medical provider: Please perform and record the results of the appropriate TB screening test(s) for this child.

BCG vaccine *Not required or recommended* • *If given date must be documented*	Date (mm/dd/yyyy): _____/_____/_____
TB Skin Test (Mantoux, PPD 5 TU) ***REQUIRED*** *if:* • *BCG more than 5 years ago, and/or* • *no history of TB disease or "positive" TB Skin Test*	Date given (mm/dd/yyyy): ____/____/_____ Date read (mm/dd/yyyy): ____/____/_____ Result (in mm induration): _____ mm
TB Interferon Gamma Release Assay (IGRA) ***MAY*** *substitute for TST in those with previous BCG vaccine*	Date (mm/dd/yyyy): _____/_____/_____ Result: _____
Chest X-ray *Required* ***ONLY*** *if:* • *new or prior "positive" TB Skin Test, or* • *history of TB disease, or* • *indicated by current health history or exam*	Date (mm/dd/yyyy): _____/_____/_____ Result:_____
Medical Examination *Required* ***ONLY*** *if:* • *new "positive" TB Skin Test, or* • *abnormal chest x-ray, or* • *BCG less than 5 years ago*	Date (mm/dd/yyyy): _____/_____/_____ Result: _____

Name of examiner: _____ **Signature:** _____

Address: _____ Designation: MD / MBBS / NP / PA *(circle)*

Email: _____ Date: _____ *(mm/dd/yyyy)*