Initial Two-Step Tuberculin (TB) Skin Test Report Form
Department of Nursing

The deadline for submission is **August 15**. The student is to email a scanned copy to dbaloun@csbsju.edu and keep a copy for personal records.

**Student Information** (please print)

Last Name ___________________________ First Name ___________________________

**Clinic Information**

Clinic Name ___________________________ City, State ___________________________ Phone ___________________________

**Please note:** If the student has recently traveled to a TB high-burden area as defined by the Centers for Disease Control ([http://www.stoptb.org/countries/tbdata.asp](http://www.stoptb.org/countries/tbdata.asp)), he/she must complete a TB Symptom Screening Form by August 15. The two-step tuberculin skin test and this form must then be completed 8-10 weeks after returning to the U.S.

☐ **Two-step Tuberculin Skin Test**

**NOTE:** QuantIFERON blood test, tine, or monovac are not acceptable.

**STEP 1:**

Date Given: _______________ Signature/Title: ___________________________________

Date Read: ________________ Signature/Title: ___________________________________

**Step 1 Results:** _____mm  **Interpretation:** ☐ Negative  ☐ Positive

* Results must be read within 48-72 hours by trained personnel.

**STEP 2 (Second tuberculin skin test must be administered 7-21 DAYS after Step 1 is READ):**

Date Given: _______________ Signature/Title: ___________________________________

Date Read: ________________ Signature/Title: ___________________________________

**Step 2 Results:** _____mm  **Interpretation:** ☐ Negative  ☐ Positive

* Results must be read within 48-72 hours by trained personnel.

☐ **Previous or current positive tuberculin skin test or received BCG**

Students who have a positive TB skin test will need to provide proof of a negative chest x-ray (CXR) and then will need to repeat the CXR only if they experience symptoms of tuberculosis.

Chest x-ray date: _________________  **Results:** ☐ Negative  ☐ Positive

Medical Treatment Plan: __________________________________________________________

Student ☐ can ☐ cannot participate in providing patient care in all clinical areas.

Provider Signature/Title: ________________________________________________________