

San Jose Parents Participating Nursery School

TB SKIN TEST FORM

TB skin tests must have been performed within 1 year prior to initial entrance to the school and renewed every 4 years thereafter. TB skin tests are available through your medical provider or the Santa Clara County Public Health Department (408)-792-5200 or www.sccphd.org/phmain/programs/12.asp for information. The child's physician may document the child's TB skin test form or the Physician's Report that the TB skin test is not required or deem the child not at risk, **providing the date of assessment, signature, and clinic/provider stamp.** The tine test (skin surface test) is acceptable only for preschool children. The skin test (PPD under the skin or intradermal test) involves two visits; one for placing the test, and another 48 to 72 hours later to have the test professionally read. **This form or other TB Test documentation must be signed by your medical provider, and include the test result, the date placed, the date read, and the clinic/physician stamp.** If both parents or grandparents/nannies/or other caretakers will be working at the school, a TB test for each person is required.

Circle one: **New Family** **New Child** **Renewal**

Child's Name _____

| Type | Date Given | Date Read | mm indur | Impression | Clinic Stamp |
|--|------------|-----------|----------|--|--------------|
| PPD-Mantoux | | | | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | |
| Tine | | | | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | |
| Provider signature/date | | | | | |
| Risk Factors Not Present: TB Skin Test Not Required. <input type="checkbox"/> Please check. Provider signature _____ | | | | | |

Parent's Name _____

| Type | Date Given | Date Read | mm indur | Impression | Clinic Stamp |
|--------------------------------|------------|-----------|----------|--|--------------|
| PPD-Mantoux | | | | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | |
| Provider signature/date | | | | | |

Parent/Caretaker's Name _____

| Type | Date Given | Date Read | mm indur | Impression | Clinic Stamp |
|--------------------------------|------------|-----------|----------|--|--------------|
| PPD-Mantoux | | | | <input type="checkbox"/> Pos <input type="checkbox"/> Neg | |
| Provider signature/date | | | | | |