

**Tuckahoe School District  
Health Offices**

**Tuberculosis Screening**

Either **A** or **B** *must* be completed by a physician. If either is *not* completed,  
this form will be returned

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(please print )

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**A).  
PPD (Mantoux ):**

Date placed \_\_\_\_\_ Date read \_\_\_\_\_ Result in mm \_\_\_\_\_ M.D. initials \_\_\_\_\_

**B). Tuberculin screening is *not* indicated at this time \_\_\_\_\_  
M.D. initials \_\_\_\_\_**

Last PPD on record · Date placed \_\_\_\_\_ result \_\_\_\_\_

**If test result is positive :**

Chest x-ray : Date \_\_\_\_\_ result \_\_\_\_\_  
INH therapy: yes \_\_\_\_\_ no \_\_\_\_\_ Date \_\_\_\_\_

Additional comments: \_\_\_\_\_

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Physician's signature \_\_\_\_\_ Stamp or Print \_\_\_\_\_  
Date \_\_\_\_\_