

**School of Nursing**  
**1601 Maple Street**  
**Carrollton, Georgia 30118**  
**TB/PPD Test Results**

**Student Name:** \_\_\_\_\_

Proof of a negative TB skin test must be obtained **EVERY YEAR** and must not expire during the clinical experience. **A Two Step Skin Test is only required of students that have just been admitted to the BSN pre-licensure program. Returning students should receive the traditional single step skin test.**

**All fields must be completed for this form to be valid.**

**TUBERCULOSIS**

Tuberculosis Skin Test, Mantoux, Purified Protein Derivative (PPD)

**Single Step Skin Test**

Date of Injection	Date of Reading (48-72 hours later)	Reading
		mm

**Two Step Skin Test (ONLY required for newly admitted BSN pre-licensure students)**

Date of Injection	Date of Reading (48-72 hours later)	Reading
		mm

If student has a history of a positive PPD or Bacilli Calmette-Guerin (BCG) vaccine then the following should apply:

**Initial documentation for students with a positive PPD must include:** Most recent positive PPD, most recent chest x-ray summary, current and/or past treatment record, as well as a letter from a nurse practitioner, physician assistant, or medical doctor stating that the student is free and clear of all signs and symptoms of TB to participate in clinical activities. A doctor's note must be obtained each year for students with a positive PPD record.

\*\* Students with positive TB skin tests must receive follow-up assessment and treatment as recommended by the Centers for Disease Control and Prevention (CDC).

*All students who take 5 or more credit hours per semester on the main Carrollton campus who have paid health fees at UWG may have the TB Skin test completed at University Health Services for no charge. However, there will be a charge if other tests are ordered. TB tests at UWG Health Services can only be done on Mondays, Tuesdays, and Wednesdays due to they have to be read within 48 to 72 hours.*

**Signature of Nurse Practitioner, Physician Assistant, or Medical Doctor:**

\_\_\_\_\_ Date: \_\_\_\_\_

Facility Address: \_\_\_\_\_

\_\_\_\_\_ Provider Telephone #: \_\_\_\_\_

Updated: 5/4/11