Tanner Health
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 on a **YEARLY basis** and must not expire during the clinical experience**. A Two Step Skin Test is required by all BSN, RN-BSN and MSN students the first year upon admission into the nursing 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	Interpretation (please circle one)
		mm	Positive Negative

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, Medical Doctor, and RN/LPN: (this document must be also have the facility information either stamped or written in below)

____ Date: ____________________
Healthcare Provider Signature

Facility Name & Address: ____
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Provider Telephone #: ____

Revised 2018