SAN MARINO UNIFIED SCHOOL DISTRICT

T U B E R C U L O S I S S K I N T E S T R E P O R T

NAME: _____

ADDRESS: _____

BIRTHDATE _____ **BIRTHPLACE** _____

TYPE OF SKIN TEST: MANTOUX (5TU PPD) ***

DATE OF TEST ____/____/_____

DATE OF READING ____/____/_____

CHECK RESULTS:

INDUR. ____**MM**

_____ **SIGNIFICANT** _____ **NON-SIGNIFICANT**

SIGNATURE OF PHYSICIAN: _____,
(OR DESIGNEE)

***** ***A PHYSICIAN'S SIGNATURE IS REQUIRED TO VALIDATE THE ABOVE SKIN TEST INFORMATION*.**

CHEST X-RAY RESULTS (REQUIRED IF SKIN TEST IS 10MM OR ABOVE)

FILM DATE: ____/____/_____ **FILM IMPRESSION:**
____ **NORMAL**
____ **ABNORMAL**

CHECK HERE ___ **IF CHILD IS FREE OF COMMUNICABLE TUBERCULOSIS**

SIGNATURE OF PHYSICIAN: _____.
(OR DESIGNEE)

******** ***CHEST X-RAY RESULTS ARE VALID ONLY WHEN ACCOMPANIED BY PHYSICIAN'S SIGNATURE*.**