



**Mail or fax completed form to:**

Virginia Reynolds – College Health Records Office  
Southwest Tech – Health Science Center  
1800 Bronson Blvd, Fennimore, WI 53809

**Phone:** 608-822-2648 **Fax:** 608-822-2776 **Email:** [vreynolds@swtc.edu](mailto:vreynolds@swtc.edu)

## TB Skin Testing Form

Name: \_\_\_\_\_ Program: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

### SECTION 1: TB SKIN TESTING HISTORY

Date of last TB skin test: \_\_\_\_\_ Result: \_\_\_\_\_ mm of induration *Note: Need to Submit copy of last TB*

**Only individuals with a history of a positive TB Skin Test result need to answer the next three questions!**

If you have had a positive TB skin test, note most recent chest x-ray \_\_/\_\_/\_\_ **Result:** Normal / Abnormal

Have you taken medication for TB (example – INH)? **Yes / No** If yes, please list the medication(s):

Have you ever been vaccinated against TB with BCG? **Yes / No** If yes, please note date(s):

### SECTION 2: MEDICAL HISTORY – TO BE COMPLETED ANNUALLY

- For questions with a YES response – please indicate reason

Do you currently have a persistent or productive cough? **Yes No**

Have you been coughing up or spitting up any blood? **Yes No**

Are you experiencing any night sweats? **Yes No**

Have you experienced any unexplained weight loss in the past year? **Yes No**

Have you been experiencing any unusual fatigue? **Yes No**

Are you experiencing symptoms of an acute infectious illness? **Yes No**

Are you immune-suppressed by disease, or drugs (i.e., corticosteroids)? **Yes No**

**If yes, list drug(s) and dosage:**

Do you currently have a rash, allergic dermatitis? **Yes No**

Have you received a recent vaccination (live virus in past 6 weeks)? **Yes No**

Have you lived in a foreign country for 2 months, or greater? **Yes No**

Have you been exposed to an individual with TB in the past year? **Yes No**

Drug or food allergies **If yes, list drug(s) and dosage:** **Yes No**

### Specific Requirements for Health Education and Public Safety Division Programs:

Associate Degree Nursing, Cancer Information Management, Child Care Services/Early Childhood Education, Dental Assistant, EMT/AEMT, Health Information Management, Medical Assistant, Medical Lab Tech, Midwife, Nursing Assistant, Paramedic Technician, and Physical Therapist Assistant

- New students are required to obtain a two-step TB skin test prior to clinical experience
- Returning students – annual TB skin testing – required  
(Submit a copy of your TB results from one year ago and your most recent TB results)

#### PLEASE NOTE:

- A TB skin test read prior to 48 hours or after 72 hours will **NOT** be accepted
- Two-step TB skin tests must be placed at a minimum of 7 days apart
- Individuals with a history of a POSITIVE TB skin test must provide a current chest x-ray result and complete this form annually
- Remember to sign this form (bottom of second or back page)
- Contact the College Health Records Office at 608-822-2648 with any questions

**SECTION 3: Health Care Provider Section**

<b>Manufacturer:</b> <b>Lot #:</b> <b>Expiration Date:</b>	<b>Manufacturer:</b> <b>Lot #:</b> <b>Expiration Date:</b>
<b>STEP #1 <input type="checkbox"/> Left volar (indicate if otherwise placed)</b>	<b>STEP #2 <input type="checkbox"/> Right volar (indicate if otherwise placed)</b>
Given By: _____ Date: _____ Time: _____	Given By: _____ Date: _____ Time: _____
Read By: _____ Date: _____ Time: _____	Read By: _____ Date: _____ Time: _____
Result: _____ mm induration	Result: _____ mm induration
<b>*Positive results are to be read by two qualified Health Care staff!</b>	<b>*Positive results are to be read by two qualified Health Care staff!</b>
Read By: _____ Date: _____ Time: _____	Read By: _____ Date: _____ Time: _____
Result: _____ mm induration	Result: _____ mm induration

I certify that the above information requested is answered correctly to the best of my knowledge.

\_\_\_\_\_  
**STUDENT SIGNATURE**

\_\_\_\_\_  
**DATE**