CENTRAL BUCKS SCHOOL DISTRICT
VOLUNTEER TUBERCULIN TEST

I. Patient Information

Last Name First MI Sex

Home Telephone Work Telephone

Mailing Address Street City State Zip

Usual Source of Medical Care Physician's Name Address Telephone

II. Required Tuberculosis Test Results (as per Regulations of the Department of Health

DATE APPLIED	ARM METHOD	ANTIGEN MANUFACTURER SIGNATURE
DATE READ	**RESULTS (mm)**	**SIGNATURE**

For previously known/new positive reactors: ______________________

Chest X-ray: Date: Results: Other: Date: Results:
(Attach a copy of the report.) (Attach a copy of the report.)

Preventive Anti-Tuberculosis Chemotherapy ordered: ☐ No ☐ Yes Date:

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE:

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The statements and answers as recorded above are full, complete and true to the best of my knowledge and belief. I understand that any false or misleading statements may cause termination of my employment.

I authorize the physician or other person to disclose any knowledge or information pertaining to my tuberculin test to the Central Bucks School District for whom this test is performed.

Signature of Volunteer Date