DMACC
DES MOINES AREA COMMUNITY COLLEGE

HEALTH AND PUBLIC SERVICES DEPARTMENT - RECORD OF TB TESTING

Complete the information below. (Please print.)

Last name _____ First Name _____ Middle Initial _____

Date of Birth _____ DMACC ID _____ Program _____ Campus _____

This section must be completed and signed by your physician (or designee.)

Tuberculin Test:
Indicate your status (check one): Term 1 student _____ Term 2,3,4,5 student _____

- If using 2-step PPD Skin Test by Mantoux (NOT TINE): a time period of more than 7 days but less than 1 year will be needed between TB skin test #1 and #2. Induration greater than 10.0 mm requires chest X-ray and prophylactic treatment consideration. Thereafter, an annual TB test (single step only) will be required.
- Quantiferon Gold blood test or T-spot TB blood test will also be acceptable and must be done annually.

TB TEST	**Date Placed** mm/dd/yy Signature of Administrator	**Date Read** mm/dd/yy	**Results in mm Induration***	**Signature of Reader**
#1 test Indicate test type:				
#2 test (if using 2-step PPD Skin Test)				

***If POSITIVE Test (equal to or greater than 10 mm) complete the following:

	Date of Chest X-ray	**Chest X-ray Results**
Chest X-ray		Copy of signed Chest X-ray report required.
Is treatment plan indicated? Check one: **_____ Yes** **_____ No**	**If treatment plan is indicated, please describe below:**	

_____ _____ _____
Date Signature of Physician (or designee) Phone

_____
Address

_____
City/State/Zip