



College of Education, Health & Public Policy  
 Office of Clinical & Field Experiences  
 1200 N. DuPont Hwy. EH 110  
 Dover, Delaware 19901  
 Phone: 302-857-6727  
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**PPD (MANTOUX) TUBERCULOSIS SKIN TEST**

(Tine or Manovac is not acceptable)

**PLEASE PRINT**

**STUDENT INFORMATION** (completed by student)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_

Student D#: \_\_\_\_\_ DOB \_\_\_\_\_

**TEST RESULTS**

Completed by Health Care Provider

**HEALTH CARE PROVIDER**

Please sign and date below

**TB SKIN TEST** use Mantoux test only

**-OR-**

**TB BLOOD TEST**

Date/Time Applied: \_\_\_ / \_\_\_ / \_\_\_ - \_\_\_ : \_\_\_

Quantiferon: \_\_\_\*

Date/Time Read: \_\_\_ / \_\_\_ / \_\_\_ - \_\_\_ : \_\_\_

Other: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_

Result: Neg. \_\_\_ Pos. \_\_\_

\*Enclose copy of lab report

Interpretation: Neg. \_\_\_ Pos. \_\_\_

\_\_\_\_\_mm induration (If no induration, mark "0")

Name of Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Provider: \_\_\_\_\_

**CHEST X-RAY\***

Chest X-Ray Date: \_\_\_\_\_

\_\_\_ Normal \_\_\_ Abnormal

\*USA chest x-ray reports only

**MEDICATION TREATMENT FOR TUBERCULOSIS**

Drug: \_\_\_\_\_

Dose and Frequency: \_\_\_\_\_

Treatment completion date: \_\_\_\_\_

**PROVIDER:** Please return completed form to student

**STUDENT:** Please return form to the Clinical and Field Experiences Office EH 110