WESTERN WAYNE
SCHOOL DISTRICT

DISTRICT OFFICE
1970c Easton Turnpike
Lake Ariel, Pennsylvania 18436

Telephone: 1-800-321-9973 Web: www.westernwayne.org Fax: (570) 341-1221

TUBERCULOSIS SKIN TEST FORM / PHYSICIAN'S REPORT

Employee/Patient Name: _____ DOB: _____

TEST	
Date on Which Test Was Applied	
Testing Location	☐ R Arm ☐ L Arm
Name of Antigen Used and Manufacturer	
Lot Number / Expiration Date	
Method	
Dose of Purified Protein Derivative	

_____
Signature (Administered By)

RESULT	
Date on Which Test Was Read	
Induration (Please note in mm)	
Test Result	☐ Negative ☐ Positive

_____
Signature (Results Read/Reported By)

Physician/Facility Name & Address

_____
_____
_____

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.

_____
_____

For previously known/new positive reactors:

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

Other: Date: _____ Results: _____ (Attach a copy of the report)

Preventive Anti-Tuberculosis Chemotherapy Ordered: ☐ No ☐ Yes Date: _____

The statements and answers as recorded above are full, complete, and true to the best of my knowledge and belief. Unless prohibited by law, I authorize the physician or other person to disclose any knowledge or information pertaining to the above results. I understand that any false or misleading statements may cause termination of my employment.

Employee Signature: _____