Tuberculosis (TB) Compliance Form

Notre Dame of Maryland University – Student Health Services

Student Information

Name: _____

Date of Birth: ___/___/_____

Student ID: _____

Phone: _____

Student Email:_____

Provider Section

(To be completed if testing is indicated or documentation is provided)

☐ TB Skin Test (TST/PPD)
Date placed: ___/___/_____
Date read: ___/___/_____
Result (induration in mm): _____ mm
☐ Negative ☐ Positive

☐ TB Blood Test (IGRA – Quantiferon/T-Spot)
Date: ___/___/_____
Result: ☐ Negative ☐ Positive ☐ Indeterminate

☐ Chest X-ray (if positive TST/IGRA)
Date: ___/___/_____
Result: _____

☐ Treatment for Latent/Active TB: _____

Provider Name & Title: _____
Signature: _____ Date: ___/___/_____
Clinic/Office Stamp: _____

Student Certification

I certify that the above information is true and complete to the best of my knowledge.

Student Signature: _____ Date: ____/____/_____