

TUBERCULIN SKIN TESTING DATABASE FOR COLLEGE STUDENTS
Arkansas Department of Health – Tuberculosis Program

Last Name: _____ First Name: _____ MI: _____

Student ID#: _____ Date of Birth: _____ Age: _____

Social Security #: _____ Enrollment Date: _____ Gender: Male Female

Race: Non-Hispanic White White Hispanic Non-Hispanic Black Black Hispanic
Asian Pacific Islander American Indian Other

What Country were you born in? _____

Have you been out of the US in the last 5? Yes No Most recent year of travel (yyyy): _____

Have you been to: Africa Asia South America Eastern Europe Other BCG? Y N Unk

Have you had an HIV test? Yes No Date(yyyy): _____ Result? Positive Negative

Previous TST? Yes No Reading (mm): _____ Date (yyyy): _____

If reading is unknown, was it read as positive or negative? Positive Negative

Location: _____

Record of Current Tuberculin Skin Test (TST)

Tuberculin Antigen Used: Tubersol Aplisol Unknown

Date of 1st TST: _____ Reading (mm): _____ Date Read: _____ Location: _____

Date of 2nd TST: _____ Reading (mm): _____ Date Read: _____ Location: _____

Date of 3rd TST: _____ Reading (mm): _____ Date Read: _____ Location: _____

Record of Current Chest Radiograph

Chest Radiograph? Yes No Date (mm/dd/yyyy): _____

Provider: _____ Test Results _____

Location: _____

Treatment Recommended: Yes No

**ARKANSAS CERTIFICATION OF TUBERCULOSIS SCREENING FOR
INSTITUTIONS OF HIGHER EDUCATION**

NAME OF STUDENT _____

BIRTH DATE _____ SSN _____

EDUCATIONAL INSTITUTION _____

I certify that a 5 TU Mantoux PPD skin test was applied on _____ and was read on _____
(mo/day/yr)

_____ by me or a licensed nurse under my supervision.
(mo/day/yr)

The reading was _____ mm induration.

Name: _____ M.D. D.O. RN/RN/LPN
 First MI Last

PHN School Nurse

Address: _____
 Street Address or P.O. Box

Signature: _____

_____ City State Zip Code

I certify that an antero-posterior erect chest radiograph was made on _____
(mo/day/yr)

and that it revealed

- no evidence of tuberculosis, with the exception of calcified lymph nodes and/or nodules.
- abnormalities consistent with scarring due to inactive tuberculosis.
- abnormalities consistent with active tuberculosis.
- If certifier is the same as above, he may check here and omit name and address below.

Name: _____ M.D. D.O.
 First M.I. Last

Address: _____ Medical Specialty: Radiology Pulmonology
 Street Address or P.O. Box

Signature _____

_____ City State Zip Code

Treatment Recommended: Yes No