California Academy of Leadership & Continuing Education [CALACE], LLC
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TUBERCULOSIS SCREENING TEST (Skin Test or Quantiferon)

Name: _____ DOB: _____ Date: _____

Reason for TST: School and Nursing facility requirement

History of TB? Yes: ___ (when)_____ No:____

If yes, do you have a chest x-ray done? _____ was it treated? _____

In the past twelve months, have you:

Had recent contact with a person with active tuberculosis?	__Yes __No
Has any condition that decreases your immune system?	__Yes __No
Traveled or lived outside of the U.S. in the past 12 months?	__Yes __No
Ever had a severe reaction to a TB skin test?	__Yes __No
Ever had the BCG vaccine?	__Yes __No

In the past twelve months, have you had any of the following?

Coughed up blood	__Yes __No	Unexplained weight loss	__Yes __No
Excessive fatigue	__Yes __No	Persistent Coughing	__Yes __No
Hoarseness	__Yes __No	Recurrent fever	__Yes __No
Loss of Appetite	__Yes __No	Shortness of breath	__Yes __No
Night sweats	__Yes __No		

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

Student's Signature: _____ Date: _____

Please notify the School or the Facility's Infection Control Nurse if you develop any of the above symptoms.

TUBERCULOSIS SKIN TEST

Date Given	Time	Site	Lot #	Exp. Date	Given By	Date Read	Time	MM	Result	Read By

Chest X-ray Date: _____ Result: _____ Quantiferon TB Gold Blood Test Date: _____ Result: _____

*Important Note: This TB Test is required by the School's partner Skilled Nursing Facilities for their clinical rotation activities. For employment purposes, other employers may or may not ask you to do another TB Test. This Test is valid for 1 year only upon the date when the student received it.