

**BATES COLLEGE REQUIRED TB TESTING FORM**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Student ID#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

If you answered **YES** to any TB Screening Questions on the *Health History, Consent to Medical Treatment and TB Screening Form*, please complete the below TB testing form.  
**The TB test must be from the last 6 months.**

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1. A Mantoux tuberculin skin test (TST) or a serum test for Interferon Gamma Release Assay (IGRA) is required regardless of BCG history.
    - a. Date TST Placed \_\_\_\_\_
    - b. Date TST Read \_\_\_\_\_
    - c. Result in mm \_\_\_\_\_
    - d. If applicable, specify which method of IGRA testing was done:
      - i. Date Drawn \_\_\_\_\_
      - ii. QFT-GIT \_\_\_\_\_ Tspot \_\_\_\_\_ Other \_\_\_\_\_
      - iii. Result: Negative \_\_\_\_\_ Positive \_\_\_\_\_ Intermediate \_\_\_\_\_ Borderline (Tspot only) \_\_\_\_\_
  
  2. If a student's TST was positive, was a confirmatory serum test with Interferon Gamma Release Assay (IGRA) done? Yes \_\_\_\_\_ No \_\_\_\_\_
    - a. If Yes, specify which method of IGRA testing was done:
      - i. Date Drawn \_\_\_\_\_
      - ii. QFT-GIT \_\_\_\_\_ Tspot \_\_\_\_\_ Other \_\_\_\_\_
      - iii. Result: Negative \_\_\_\_\_ Positive \_\_\_\_\_ Intermediate \_\_\_\_\_ Borderline (Tspot only) \_\_\_\_\_
    - b. If No, see question 3
  
  3. If a student's TST or IGRA is positive a Chest X-ray is required:
    - a. Date of Chest X-Ray: \_\_\_\_\_
    - b. Result: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_
  
  4. If a student has a positive PPD or IGRA without signs of active disease on chest x-ray, it is recommended that he/she be treated for latent TB prior to matriculation.
    - a. Student has already completed treatment \_\_\_\_\_ Dates of treatment \_\_\_\_\_
    - b. Student agrees to receive treatment \_\_\_\_\_
      - i. Will treatment be completed prior to matriculation at Bates College? Yes \_\_\_\_\_ No \_\_\_\_\_
    - c. Student agrees to receive treatment at Bates College \_\_\_\_\_
    - d. Student declines treatment at this time \_\_\_\_\_

Healthcare Provider signature \_\_\_\_\_

Printed Name and credentials \_\_\_\_\_

Practice Location \_\_\_\_\_

Date signed \_\_\_\_\_

**Every student must sign below**

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I acknowledge that the above statements are true to the best of my knowledge and belief.

Student Signature: \_\_\_\_\_

Date signed: \_\_\_\_\_