Mississippi Department of Human Services
Division of Youth Services

T B Skin Testing Record

Name:________________________

DOB:________________________

ALLERGIES:____________________

Student ☐ **Employee**☐

Tuberculin Testing: (inject 0.1cc,Intradermal Single dose administration inner aspect left forearm)

Past Positive **PPD** Date:_____________ ☐unknown

CXR Date:_______________ Results:________________

	Date Given	MFR.	Lot#	Exp Date	Nurse Initials	Facility	Result Date	Reaction	Nurse Initials	CXR Date	CXR Result	Physician Review
PPD Test												
PPD Test												

Positive Test: (current or past- nurses complete the following assessment)

Signs/Symptoms of **TB**	Check Box	Nursing Comments
Fatigue (weakness,tiredness)	**Y** ☐ **N**☐	
Anorexia (nausea)	**Y** ☐ **N**☐	
Weight loss	**Y** ☐ **N**☐	
Night Sweats	**Y** ☐ **N**☐	
Productive Cough	**Y** ☐ **N**☐	
Hemoptysis	**Y** ☐ **N**☐	
Chest Pain	**Y** ☐ **N**☐	
Contact w/ **TB** case	**Y** ☐ **N**☐	

Health Department notified of Positive: Date:_______________ Time:__________ Initials___________

INH Treatment of Latent TB Infection

Start Date	End Date	Transition Date (back to home Health Dept)	Comments:
Physician Signature:			

Initials	Signature/Title	Initials	Signature/ Title