SUSQUEHANNA COMMUNITY SCHOOL DISTRICT
3192 TURNPIKE STREET
SUSQUEHANNA, PA. 18847

Applicant's Name:____

Applicant's Address:____

Required Tuberculosis Test Results (as per Regulations of the Department of Health)

<table>
<tr><td>Date Applied</td><td>Arm</td><td>Method</td><td>Antigen</td><td>Manufacturer</td><td>Signature</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Date Read</td><td colspan="2">Results (mm)</td><td colspan="3">Signature</td></tr>
<tr><td></td><td colspan="2"></td><td colspan="3"></td></tr>
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For previously known/new positive reactors: ____________________________________

Chest X-ray: Date: __________ Results: ________ Other: Date: ________ Results __________
(Attach a copy of the report.) (Attach a copy of the report.)

Preventive Anti-Tuberculosis-Chemotherapy ordered: ☐ No ☐ Yes Date: __________

IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE APPLICANT IS FREE FROM CURRENT TUBERCULOSIS DISEASE OR IS UNDER ADEQUATE CHEMOTHERAPY FOR TUBERCULOSIS DISEASE. ____

______________________________ ______________________________
HEALTH CARE PROVIDER – SIGNATURE HEALTH CARE PROVIDER – PRINT

(Prior TB test results can be accepted if the test was given within one year of your start date)