SANTA MONICA COLLEGE
Student Health Services

SANTA MONICA COLLEGE
TUBERCULOSIS CLEARANCE FORM
FOR STAFF

Last Name _____ First Name _____

Address _____

Date of Birth _____

TB Testing Information

Testing Solution Used: Mantoux 0.1 mL

Manufacturer _____ Lot # _____ Expiration Date_____ Date Given _____ Site_____

Given By:_____ MD, RN, LVN (please circle one)

Date Read _____

Results: Negative:_____ mm induration Positive: _____ mm induration

If positive, referred for chest x-ray at: _____

Read By: _____ MD, RN, LVN (please circle one)

Health care providers business stamp must be included on any form or letter provided by the provider