



**Health Center Registration  
TB Testing**

\_\_\_\_\_  
CADET/CAMPER Last Name

\_\_\_\_\_  
CADET/CAMPER First Name

\_\_\_\_\_  
D.O.B:

**TB MANTOUX TEST**  
**Yearly for ALL International CAMPERS.**  
**Must ONLY be completed with in 30 days prior to**  
**arrival.**

**TB MANTOUX TEST**

Date of test: \_\_\_/\_\_\_/\_\_\_ Date results were read: \_\_\_/\_\_\_/\_\_\_

mm induration: \_\_\_\_\_  Pos\*  Neg

Manufacturer: \_\_\_\_\_ Lot#: \_\_\_\_\_ exp.: \_\_\_\_\_

Site: Left Right (Forearm) Administered by Title) \_\_\_\_\_ Time: \_\_\_\_\_

Read By (Title/print & signature): \_\_\_\_\_ Time: \_\_\_\_\_

**\*Chest X-Ray (Necessary if skin test is positive)**

**Film Date:** \_\_\_/\_\_\_/\_\_\_

**Impression:**  Normal  Abnormal

**Person is free of Communicable Tuberculosis:**  Yes  No

**Practitioner's Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Office Stamp and/or Seal required:**