DURHAM COLLEGE SUCCESS MATTERS + CAMPUS HEALTH CENTRE

Yearly One Step TB Test Requirement Form

Instructions for Completing the Yearly One Step TB Test Requirement Form

Students: Please take this entire form with you to your Health Care Provider for completion

In order to attend your clinical placement, you must provide proof of your tuberculosis (TB) status prior to placement.

- If your previous TB test was **NEGATIVE:** please complete Part B below with your current 1 step TB test. TB tests are valid for 1 year.
- If your previous TB test was **POSITIVE:** please complete Part C below with your physician. Attach your chest X-ray report. This may be a new chest x-ray or your original chest x-ray dependent on your physician's assessment. Repeat TB testing is not recommended.

TB testing can be completed by your family physician, at the Campus Health Centre or the Public Health Department. You may be required to pay a fee for the test.

A signature and contact information of the physician or nurse completing this form must be completed.

For more information or to request alternate formats of this form for accessibility, please contact your field placement officer. All information must be transcribed to this form. Supporting documents alone will not be accepted.

PART A: STUDENT PERSONAL INFORMATION (to be completed by student)

First Name: Last Name:

Student Number:

Program of Study:

Date of previous Tuberculin Test: Result: mm

NOTE: After Part A above has been completed, you must print this form and take it with you to your scheduled appointment with the physician or nurse. Print

PART B: YEARLY 1 STEP TB TEST (to be completed by healthcare provider)

One-step TB test (read 48-72 hours after planting)

Date Given:_____ Date Read:_____

Site R/L forearm result_____ mm

PART C: ASSESSMENT FOR PAST OR CURRENT POSITIVE TB TEST

Students who test positive for TB must provide annual documentation from their Health Care Provider indicating there are no signs or symptoms of active Tuberculosis. The assessment may or may not include a new chest x-ray.

Date of Positive TB Test:_____ Treatment:_____Yes_____No

Does this student show signs of active TB: _____Yes_____No

Does this student require an updated chest x-ray: _____Yes_____No

Attach original or new chest x-ray report.

PART D: CLINIC STAMP AND SIGNATURE OF PHYSICIAN OR NURSE

Physician or Nurse Name (please print):_____

Clinic Address:_____

Clinic Telephone #:_____

Signature: _____Date (yyyy-mm-dd):_____

Please place a clinic stamp or write the clinic address with postal code and phone # in the box below:

Notice of Collection

All documentation of records submitted to or created by the Campus Health and Wellness Centre (CHWC) are the property of the client/patient and the Campus Health Centre is the custodian of that information.

All records are maintained in a confidential manner in accordance with the Personal Health Information Protection Act (PHIPA) S.O. 2004 Chapter 3, Schedule A, Part IV (Collection, Use and Disclosure of Personal Health Information), and Health Care Consent Act 1996, Regulated Health Professionals Act 1993, the Mental Health Act 2002 and the policies of Durham College.