STUDENT HEALTH SERVICES
478 S. JOHNSON ST. – 3RD FLOOR
NEW ORLEANS, LA 70112
OFFICE (504) 568-1800
FAX 504-568-1799

Annual TB Skin Test

Name: _____
Last First

DOB: _____

Program: AH DS GS MED NUR

____Date Administered: _____

____Test Site: _____

____Administered by: _____

Patient instructed and agrees to return to clinic within 48-72 hours for reading of TB skin test _____
Initial here

For office use only

Result: NEG@_____mm POS@_____mm _____ _____
Date Read & Time Name of Person

☐ **CXR Neg Pos**

☐ **INH** ☐ **Student Health to manage INH**

☐ **Wetmore to manage INH**

☐ **TB sx discussed w/pt**

****PLEASE UPLOAD COMPLETED FORM TO: THE STUDENT HEALTH SUBMISSION PORTAL**
***Go to the LSU Health New Orleans Homepage, click MYLSUHSC>Self Service>Academic Self-Service, you must login and continue to upload your completed form.**