PLATT COLLEGE

Standardized Immunization Form: TB/Chest X-Ray Only

Patient Section

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Last 4 SS#:		**City:**			
Phone:		**State:**			
Email:		**ZIP Code:**			

Below Section: MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER

Printed Name of Healthcare Provider:	
Title:	
Address Line 1:	
Address Line 2:	
City:	
State:	
ZIP Code:	
Phone:	
Fax:	
Email Contact:	

Authorized Signature of Healthcare Provider: _____

Date: _____

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Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Tuberculosis Screening – TB Skin Tests/PPDs are required annually: TB or Chest X-Ray must be negative
*Some clinical sites will not accept the Quantiferon-TB Blood Test which could result in delay of clinical placement.

Option 1		Date Placed	Date Read	Reading	Interpretation
Tuberculosis Skin Test	TB Skin Test/PPD Given	___/___/___	___/___/___	_____ mm	☐ Positive ☐ Negative ☐ Equivocal
Option 2		Date Taken	Interpretation		Documentation
Chest X-Ray	Chest X-Ray Taken	___/___/___	☐ Normal ☐ Abnormal		Must Provide Documentation