Wesleyan University
Davison Health Center
327 High Street, Middletown, CT 06459
860-685-2470 phone 860-685-2471 fax
healthforms@wesleyan.edu

TUBERCULOSIS TESTING FORM

If you answer YES to any questions on your TB Screening Questionnaire, TB testing is required. Please take this form to your Health Care Provider for completion. If TB Blood Test or TB Skin Test is positive, a Chest X-ray is required. All testing and Chest X-RAY (if required) must be within 6 months of your matriculation date. **Upload copy of TB test result and/or Chest X-ray report to the Student Health Portal.***

TB BLOOD TEST (IGRA) **OR** **TB SKIN TEST (TST)**

Preferred if prior BCG

☐ Quantiferon ☐ T-Spot

Date: ____/_____/_____

Result ☐ NEG ☐ POS ☐ INDETERMINATE

Mantoux skin test only.

Date planted: _____/_____/_____
Date Read: _____/_____/_____
Result in induration _____ mm

If no induration, mark "0"

CHEST X-RAY: Required within 6 months for past or current positive TB Blood or Skin test.

Chest X-Ray Date: ____/_____/_____

Result: ☐ NORMAL ☐ ABNORMAL

MEDICATION TREATMENT

☐ Latent TB Infection ☐ Active TB disease

Treatment Regimen: _____

Duration: _____ Completion Date: __/___/___

_____ _____
Health Care Provider Signature **Date**

_____
Health Care Provider Printed Name

Address (Print or Stamp) _____

City _____ **State** _____ **Zip** _____

Phone (_____) _____ **Fax** (_____) _____

*Submit completed form and any attachments by scanning and uploading to the Student Health Portal – wesleyan.medicatconnect.com.