Tuberculosis Skin Test Form

Healthcare Professional Name: _____

Testing Location: _____

Date Placed: _____

Site: ☐ Right ☐ Left

Lot #: _____ Expiration Date: _____

Signature (administered by): _____

☐ RN ☐ MD ☐Other: _____

Date Read (within 48-72 hours from date placed): _____

Induration (Please note in MM): _____MM

PPD Test Result: ☐ Negative ☐ Positive

Signature (results read/reported by): _____

☐ RN ☐ MD ☐Other: _____