College of Nursing
3800 Victory Parkway
Cincinnati, OH 45207-7351
513 745-3814

XAVIER UNIVERSITY

TB (Tuberculosis) TEST VERIFICATION FORM

Applicable to: All BSN, MIDAS and FNP students.

STUDENT: COMPLETE THIS SECTION

I understand that prior to starting my first-year practicum courses I must obtain and submit documentation of a negative TB test using one of the following: 2-step skin test OR QuantiFERON blood test OR T-Spot blood test.

Annually thereafter I must obtain and submit proof of absence of tuberculosis using one of the following: 1-step skin test OR QuantiFERON blood test OR T-Spot blood test.

If I have a positive TB test the following are required: negative/clear chest X-ray results and annual TB Questionnaire. Additional tests results are required within 12 months of pediatric practicum experiences.

If my health status changes, I will inform the College of Nursing and my instructor to avoid putting my health and academic status at risk. It is my responsibility to maintain copies of my medical documents.

Student signature _____ Date _____

Student printed name _____ DOB _____

HEALTH PROFESSIONAL: COMPLETE THIS SECTION

Mantoux Skin Test #1 (1-STEP testing is *only* approved for RENEWAL in the 2nd year)

Date Given _____ Given by _____
Signature & Credentials

Must be read within 48 to 72 hours by a licensed healthcare professional.

Date Read _____ Read by _____ Result _____ record as MM induration
Signature & Credentials

Mantoux Skin Test #2 (STEP #2 is REQUIRED in the first year and must be GIVEN 1-3 WEEKS AFTER STEP #1)

Date Given _____ Given by _____
Signature & Credentials

Must be read within 48 to 72 hours by a licensed healthcare professional

Date Read _____ Read by _____ Result _____ record as MM induration
Signature & Credentials

NAME/ADDRESS/PHONE OF HEALTH CARE PROVIDER

_____

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PLEASE PROVIDE ALTERNATE FORMS OF VERIFICATION OF ABSENCE OF TB:

Provide documentation of a negative QuantiFERON blood test or negative T-Spot blood test result.
Provide documentation of a negative chest X-ray (<12 months old).
Provide completed TB Questionnaire annually *after* submitting initial positive TB test AND negative chest X-ray.

NAME/ADDRESS/PHONE OF HEALTH CARE PROVIDER (if not on attached verification):

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