# Youth Annual PPD Testing Form

It is recommended all employees and volunteers have annual PPD skin testing.  This tuberculosis screen is recommended by both the Centers for Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA).

Retain this form through the entire PPD testing process.  Bring this form to the Employee Health Unit for your testing.  The appropriate individual who reads your test must sign this form.  Tests are read 48-72 hours after being placed on your forearm.  *Employees are not permitted to read and report their own test results.*

Volunteer Name: ____________________________________ Service Line: --PCS

(Patient/Guardian Signature if under 19 years of age: _________________________________
*(Please Print)*

Volunteer SSN: _______________________________ DIVISION: ___________________

Note: *Individuals with severe immunosuppression (e.g. during chemotherapy, radiation therapy, on oral steroids or Methotrexate or HIV positive individuals) or pregnancy should speak with the Employee Health provider prior to testing.  Persons who received BCG over 15 years ago should be tested.*

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| | | |
|---|---|---|
| PPD PLANTED: Site | Date | *Lot #* |
| Date PPD scheduled to be read: | | |
| PPD Results mm | Date Read | |
| Signature of Reader | | |

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**IF YOU HAVE A HISTORY OF POSITIVE REACTION TO THE PPD TEST, YOU DO NOT NEED TO BE TESTED.** Please answer the following questions and return this form to the Employee Health Unit through the interoffice mail.

Have you experienced the following symptoms in the past year?

| | | |
|---|---|---|
| Persistent, unexplained cough for more than two weeks | Yes | No |
| Persistent, unexplained fever for more than two weeks | Yes | No |
| Persistent, unexplained weight loss | Yes | No |

Volunteer Signature: ____________________________________Date Returned ____________

(Patient/Guardian Signature if under 19 years:

_______________________________________
*(Signature)*