IMMUNITY VERIFICATION PROGRAM
UNIVERSITY of WASHINGTON

Health Sciences Immunization Program (HSIP)
Positive TB Screening Form

Health care providers (MD, DO, ARNP, PA, RN or other appropriate designee) may use this form to document a student's positive PPD and/or completed prophylactic treatment if other documentation is unavailable. This form is not acceptable when completed by a student or relative.

For students with a history of active TB disease, please contact HSIP at myshots@uw.edu for instructions.

Student last name: _____ Student first name: _____

Student ID#: _____ UW NetID: _____

Positive PPD: If student has had a positive TB skin test (*greater than or equal to 10mm*), the provider may verify the student's history by noting it below.

PPD placed: _____ (MM/DD/YYYY) PPD read: _____ (MM/DD/YYYY) PPD result: _____ mm
A positive result is ≥ 10 mm.

Prophylactic Treatment: UW health sciences students with a positive PPD or IGRA are not required to complete prophylactic treatment. **For students who completed prophylactic treatment**, the provider may verify the student's treatment history by noting it below.

Rx/medication type: _____

Date started: _____ (MM/DD/YYYY) Date ended: _____ (MM/DD/YYYY) Duration: ____months

Required: Health Care Provider Authentication

I certify the accuracy of the dates and other information on this form.

Signature: _____ **circle one**: MD, DO, ARNP, PA, RN

Printed Name: _____

Phone #: _____ Date: _____

FACILITY STAMP