Community Care Resources, Inc.

Partnership in Planning

TB Test Documentation

Name of Youth:_____ **Date of Birth:**_____

Foster Parents:_____ **Clinic Name:**_____

☐ **TB Test Administered**

Date Test Administered:_____ **Date TB Test Read:**_____

Results:_____

Test Administered by:_____

Signature:_____

☐ **TB Test NOT Administered** **Date of Risk Assessment:**_____

A TB risk assessment has been completed for the above-name individual. The person does not have risk factors, or if tuberculosis risk factors were identified, he/she has been examined and determined to be free of infectious tuberculosis

Comments:

Physician's who Administered Assessment:_____

_____

Physician's Signature

Form Updated 02/2018

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