

New Millennium Health Care

Tuberculin Skin test Form

Employee Name and Title _____ Date _____

- I hereby authorize _____ to release a copy of my tuberculin skin test to New Millennium Health Care
- I hereby authorize New Millennium Health Care to administer a tuberculin skin test to me. I agree not to hold New Millennium Health Care responsible for any adverse reactions that may occur.

Employee Signature _____ Date _____

If authorized to release information regarding a copy of my tuberculin skin test, then please send to:

New Millennium Health Care
7931 N.E. 6th Street
Spring Lake Park, MN 55432
Fax 763-795-8878

If authorized to administer tuberculin skin test by New Millennium please continue.

Date Administered _____
Dose _____
Lot Number _____
Expiration Date _____
Site _____

Administered by (signature and title) _____

Date results read (48 to 72 hours later) _____
Results of mm of induration _____
Read by (signature and title) _____

Follow up action if result is significant (>10 mm of induration)

