Hoosier Youth ChalleNGe Academy
10892 N State Road 140, Knightstown, IN 46148
Toll Free: 1-877-860-0003 Option: 2 / Fax: 765-345-1024
Website: in.gov/ago/hyca

Tuberculosis (TB) Skin Test Form

Applicant Name: _____ Date of Birth: _____

Form is to be completed by a Healthcare Professional only. Complete ALL fields on this form.

TB test that are read before 48 hours or after 72 hours from administration will NOT be valid.

TB Test Placement:

Date test was administered: _____ Time test administered: _____

Site: _____ Right Forearm _____ Left Forearm

Administered by: _____ Title: _____

TB Test Results:

Date test was read: _____ Time test was read: _____TB Test Induration: _____mm

Final Results (Interpretation based on mm of induration, as well as, risk factors): ____Negative ____ Positive

Read by: _____ Title: _____

Does this Patient need to have a chest x-ray? _____ Yes _____ NO

Date of chest x-ray? _____ Results of chest x-ray: _____Positive _____Negative

Please attach x-ray results if one was needed to confirm results.

Date Latent TB medications were started:_____

Name of Physician's Office / Clinic:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Place Stamp Here: