

Mississippi Department of Human Services  
Division of Youth Services

**T B Skin Testing Record**

**Tuberculin Testing:** (inject 0.1cc, Intradermal  
Single dose administration inner aspect left forearm)

Past Positive PPD Date: \_\_\_\_\_  unknown

CXR Date: \_\_\_\_\_ Results: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

Student

Employee

	Date Given	MFR.	Lot#	Exp Date	Nurse Initials	Facility	Result Date	Reaction	Nurse Initials	CXR Date	CXR Result	Physician Review
PPD Test												
PPD Test												

**Positive Test:** (current or past- nurses complete the following assessment)

Signs/Symptoms of TB	Check Box	Nursing Comments
Fatigue (weakness, tiredness)	Y <input type="checkbox"/> N <input type="checkbox"/>	
Anorexia (nausea)	Y <input type="checkbox"/> N <input type="checkbox"/>	
Weight loss	Y <input type="checkbox"/> N <input type="checkbox"/>	
Night Sweats	Y <input type="checkbox"/> N <input type="checkbox"/>	
Productive Cough	Y <input type="checkbox"/> N <input type="checkbox"/>	
Hemoptysis	Y <input type="checkbox"/> N <input type="checkbox"/>	
Chest Pain	Y <input type="checkbox"/> N <input type="checkbox"/>	
Contact w/ TB case	Y <input type="checkbox"/> N <input type="checkbox"/>	

Health Department notified of Positive: Date: \_\_\_\_\_ Time: \_\_\_\_\_ Initials \_\_\_\_\_

**INH Treatment of Latent TB Infection**

Start Date	End Date	Transition Date (back to home Health Dept)	Comments:
Physician Signature: _____			

Initials	Signature/Title	Initials	Signature/ Title