foundations
health & wholeness

TB Test Documentation

Foster Child: ______________________________________ DOB: ___________

Please fully complete the below information, including one of the two outlined boxes.

TB test was performed on the following date: _______________________

Date read: _______________________

Results: _________________________

OR

Date TB test denied by physician: ________________

Reason for denial of test: ____

____

Date or Age at which child can be tested: _____________________

____
Print name of Authorizing Person

____
Clinic

____
Address

____
Authorized Signature