# San Mateo Union High School District

## TUBERCULOSIS CLEARANCE FORM

**Student: _____ DOB: _____ Grade: _____ School: _____**

Dear Parent/Guardian: Date: _____

Your son/daughter has elected to participate in a school program which requires tuberculosis clearance as follows:

**[ ]** Teenage students working with preschool-aged children, for example (Child Care, nursery school programs) or elementary-aged children (School/Community Service) are required to have an **annual** tuberculosis clearance.

**[ ]** Teenage students working as school employees (Food Service and/or Workability), are required to have tuberculosis clearance **every four years.**

A tuberculosis clearance given within the time periods stated above **in writing by a physician,** will satisfy the requirement.

A tuberculin clearance may be obtained through your student's own physician or clinic.

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## PHYSICIAN'S REPORT OF TUBERCULOSIS CLEARANCE

Name: _____

Birthdate: _____

TST/P.P.D. Date: _____ Result: _____

X-Ray Date: _____ Result: _____

QuantiFERON Date: _____ Result: _____

Recommendations: INH _____ mg/daily for 9 months.

Date Started: _____ Date Completed: _____

Remarks: _____

***Not Valid Unless Signed, Stamped & Dated***

**Date form completed:** _____ **NAME:**
**ADDRESS:**
**PHONE:**

_____
**Signature of Physician/Clinic**

**PLEASE STAMP/AFFIX NAME, ADDRESS, AND CONTACT INFORMATION**

Health Office review/approval _____ Date: _____
Signature of Health Aide or District Nurse

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