



Authorized by the  
Tennessee Higher  
Education Commission

# Prepare To Care

Training Center, Inc

750 Broad St NW  
Suite 201  
Cleveland, TN 37311  
(423) 614-3838

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## Tuberculin PPD Intradermal Test

I, \_\_\_\_\_ hereby give my permission to  
\_\_\_\_\_  
\_\_\_\_\_  
(facility name) to administer a tuberculin PPD  
intradermal test in accordance with facility policy. I hereby release the associates of the above  
stated facility from the responsibility of the test.

Student Signature: \_\_\_\_\_ Date Given: \_\_\_\_\_

Vial Number: \_\_\_\_\_ Vial Expiration Date: \_\_\_\_\_

Signature of Nurse: \_\_\_\_\_

### PROCEDURE

1. Ask Associate if he/she has had a previous positive PPD. If so, do not administer and refer Associate to the PTC Coordinator/Director.
2. Give 0.1 ml of tuberculin PPD interdermal, make sure you have a good bleb.
3. The site of the test is in the flexor surface of the forearm, approximately 4 inches below the elbow.
4. The skin test number must be read at 48 hours and 72 hours after injection.
5. In the event the injection is delivered subcutaneously, (i.e., no bleb will form) or if a significant part of the dose leaks from the site, the test should be repeated immediately at another site at least 2 inches away.

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### INTERPRETATION OF TUBERCULIN REACTION

Positive – induration measuring 10 mm or more

Doubtful – induration measuring 5-9 mm

Negative – induration of less than 5 mm

Induration should be considered in interpretation of the test. If positive or doubtful, please refer Student to the PTC Coordinator/Director.

Results: \_\_\_\_\_

Date: \_\_\_\_\_



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## HEALTH EVALUATION

**ALL APPLICANTS MUST SUBMIT A HEALTH STATEMENT FROM A PHYSICIAN, PA OR NURSE BEFORE BEGINNING CLASS. ALL STUDENTS AND INSTRUCTORS WILL MEET ALL HEALTH REQUIRMENTS OF THE FACILITIES WHERE THEY ARE ENGAGED FOR CLINIAL PRACTICUMS**

### TO BE COMPLETED BY STUDENT:

1. Are you presently in good health?    YES    NO  
(If you answered NO please explain on the back of this form – use additional pages if needed)
2. Have you had any serious illness or injury in the past 12 months?    YES    NO  
(If you answered YESs please explain on the back of this form – use additional pages if needed)
3. Are you currently taking any medications?    YES    NO  
(If you answered YES please explain on the back of this form – use additional pages if needed)
4. Have you ever had a back injury?    YES    NO  
(If you answered YES please explain on the back of this form – use additional pages if needed)

I certify that the above statements are true and correct;

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**THIS PORTION TO BE COMPLETED BY NURSE, PHYSICIAN OR PA INDICATING THE STUDENT IS IN GOOD HEALTH AND ABLE TO SAFELY ENGAGE IN WORK THAT WILL INVOLVE LIFTING.**

Student Temperature    \_\_\_\_\_  
Student Blood Pressure    \_\_\_\_\_  
Student Weight    \_\_\_\_\_

Student Pulse    \_\_\_\_\_  
Student Height    \_\_\_\_\_

Any apparent physical limitations ?

\_\_\_\_\_  
Signature of Person Completing Physical

\_\_\_\_\_  
Date