Communicable Disease Screening

(To be completed by a physician)

Name of Resident Applicant: _____

Residents must be screened for any communicable disease including tuberculosis.

Date of Mantoux TB Skin Test: _____ Result: _____
Date of Last Chest X-Ray: _____ Result: _____

The person **is** _____ or **is not** _____ free of communicable disease in any apparent form.

Immunization History:

Pneumococcal Vaccine	Date: _____
Tetanus Vaccine	Date: _____
Flu Vaccine	Date: _____

May this person consume alcoholic beverages? Yes _____ No _____

Allergies:

_____
_____
_____

_____ _____
Physician Signature Date

05/04/18