

**CO-OP PARENTS' MEDICAL FORM**

DATE \_\_\_\_\_

Parents who are new to Trinity are **REQUIRED** to obtain a T.B. Test and submit results for our files.

Parent Name \_\_\_\_\_ Child's Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

\_\_\_\_ I am a returning parent within the last two years and have a T.B. test on file.

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**T.B. TEST RESULTS**

**1. Intradermal Tuberculin Test (Skin Test)**

Date \_\_\_\_\_ Result \_\_\_\_\_

**OR**

**2. Chest X-Ray (Required if Skin Test is positive)**

Date \_\_\_\_\_ Result \_\_\_\_\_

**OR**

**3. Attach TEST RESULT CARD to this form!**

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PHYSICIAN'S SIGNATURE:

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
address

\_\_\_\_\_  
phone