Lakehead UNIVERSITY | School of Nursing

1-Step TB Skin Test

Annual Requirement for 2nd, 3rd & 4th Year BScN Students

Student Name: ________________________________
(Please print your name here)

To Be Completed By Healthcare Provider	
1-Step:	
Date Administered: ________________________	**Administered by:** ________________________ (please print) (signature) ________________________
Date Read: ________________________	**Read by:** ***(if different than "Administered by")*** ________________________ (please print) (signature) ________________________
Result: ☐ Negative ☐ Positive Size mm	***Provide name & address of clinic or stamp with that information*** ________________________ ________________________ ________________________

The information on this form is collected under the legal authority of the College and Universities Act, R.SO. Ch.272, S5: R.R.O. 1980, Reg.840 for the purpose of communicating, evaluating and assisting with medical care during your academic year. If you should have any questions regarding the collection of this information please contact School of Nursing, Lakehead University, 955 Oliver Rd., Thunder Bay, ON P7B 5E1 (807)-766-7145.