Vallecitos

SCHOOL DISTRICT

Print Name: _____
Last Name First Name Middle Name Date of Test/X-Ray

Home Address: _____
Number and Street City Zip

School District: _____

## CERTIFICATE OF TUBERCULOSIS EXAMINATION

I certify that I am a physician and surgeon licensed under Chapter 5 Division 2 of the Business and Professions Code, of the state of California, that I have examined the results of the intradermal tuberculin test (and x-ray if test was ≥ 10 mm) of the above-named person and that I found him/her free from active tuberculosis.

Please check appropriate box below:

☐ Intradermal PPD was negative (<10 mm)
☐ Intradermal PPD ____ mm followed by chest X-ray.

Physician Name: _____

Physician's Signature: _____

Phone #: _____ Date: _____

**THIS FORM MUST BE FILED WITH YOUR SCHOOL DISTRICT (EDUCATION CODE SECTION 49406)**

**5211 Fifth Street, Rainbow, CA 92028 Phone: 760-451-8200 Fax: 760-728-7712**