



TUBERCULOSIS TEST FORM

Student Name: _____ ECC ID or Date of Birth: _____

East Central College requires all students answering “yes” to one or more of the tuberculosis (TB) screening questions on the Application for Admission to complete this TB Test Form prior to enrolling in coursework (per Missouri Senate Bill 197).

If the student has completed TB testing within the last 12 months, a copy of those results can be submitted in lieu of completing this form. Please submit any additional information given to you, along with this form, to:

Admissions
East Central College
1964 Prairie Dell Road
Union, MO 63084
admissions@eastcentral.edu

The information below is to be completed by a medical professional.

TB Test

Patient Name: _____ Date of Birth: _____

TB Test Date: _____ Date TB Test was Read: _____ TB Test Result: _____

Name of Medical Professional: _____ Signature: _____

Chest X-Ray (Only required, if TB Test is positive.)

X-Ray Date: _____ Date X-Ray was Read: _____ X-Ray Result: _____

Name of Hospital/Clinic: _____

Address: _____

Phone: _____ Date: _____

Name of Medical Professional: _____ Signature: _____