

CO-OP PARENT MEDICAL FORM

Parents who are new to Trinity, or who have not had a child enrolled in the past two years, are **REQUIRED** to obtain a T.B. test and submit results for our files.

DATE: _____ CHILD'S NAME: _____

PARENT NAME: _____

HOME ADDRESS: _____

CITY: _____ ZIP: _____

I am a returning parent and have T.B. test results on file.

My test results card is attached to this form.

T.B. TEST RESULTS

INTRADERMAL TUBERCULIN TEST (SKIN TEST)

Date: _____ Result: Negative Positive

CHEST X-RAY (Required if Skin Test is positive)

Date: _____ Result: Negative Positive

PHYSICIAN / HEALTHCARE PROVIDER INFORMATION

NAME: _____

ADDRESS: _____

PHONE: _____

Signature