YOLLE INSTITUTE

Yolle Institute TB Screening & Clearance

Complete this form and attach your Tuberculosis (TB) test to obtain your medical clearance from Yolle Institute.

Please print clearly and mark all applicable boxes with an X.

Student Name _____ DOB _____ MM/DD/YYYY

Program _____ Date of Screening _____ MM/DD/YYYY

TB Risk Assessment

Previous positive TB: ☐ Yes ☐ No

Close contact with active TB: ☐ Yes ☐ No

Persistent cough: ☐ Yes ☐ No

Night sweats: ☐ Yes ☐ No

TB Test

PPD Date _____ MM/DD/YYYY

Result: ☐ Negative ☐ Positive

OR IGRA Result: ☐ Negative ☐ Positive

Chest X-ray (if indicated) _____

Provider Clearance

Clearance status: ☐ Cleared ☐ Not Cleared

Comments _____

Provider Name _____ License # _____ Signature _____

Date _____ MM/DD/YYYY Student Signature _____ Date _____ MM/DD/YYYY