JACKSON COUNTY HEALTH DEPARTMENT
Consent for Tuberculin Skin Test

I authorize Jackson County Health Department to administer a Tuberculin Skin Test to myself/my child. I understand that this is only a screening test for tuberculosis (TB), and that additional testing and/or a chest x-ray will be necessary to complete my screening for TB for a positive reading. I understand that this test needs to be read within the time stated below from administration unless otherwise instructed.
After administration of this test <u>you must return within 48-72 hours for the reading</u>.

Please answer the following questions.

1. Has the adult/child **<u>EVER HAD A POSITIVE TB SKIN or BLOOD TEST</u>**? Yes No
   If yes, has the adult/child ever taken medication for Latent Tuberculosis Infection or Active Tuberculosis Disease? Yes No

2. In the past 30 days, has the adult/child received a live virus vaccine such as MMR (Measles, Mumps, Rubella), Varicella (Chickenpox), Flu Mist (nasal spray), Typhoid, Yellow Fever)? Yes No

3. Was the adult/child born or raised outside the United States? Yes No
   If yes, did he/she receive BCG vaccine? Yes No
   I understand that if I was born outside the United States, I may have received BCG vaccine, in which case, the blood test for TB is the preferred TB test. If I choose to have a Tuberculin Skin Test administered today, I may still need a TB blood test, at additional expense to me and delay in determining my TB screening status.

4. Has the adult/child received BCG bladder cancer treatment? Yes No

5. Does the adult/child have any medical conditions that lower the body's resistance to infection, such as diabetes, HIV or cancer, gastric bypass surgery? Yes No

6. Is the adult/child taking any drugs or treatments that lower the body's resistance to infection? Yes No
   Please list: _____

Nurse comments: _____

_____

INFORMATION ABOUT PERSON TO RECEIVE TEST (Please Print) **OFFICE USE ONLY IN BOLD**							
Last Name	First Name	MI	Birth date	Age	Gender	Race	Ethnicity
Address - Street		City		State	Zip		
Phone Number		County	**1st step L / R Forearm 0.1ml PPD**			**2nd step R / L Forearm 0.1ml PPD**	
Signature of person to receive test or person authorized to make the request Date _____ ✗						**Reading date:** _____ MM _____	
Signature of Nurse Administering Test Date _____ ✗						**Lot#/ Exp date**	