

CONSENT FOR TUBERCULIN SKIN TEST

Last Name	First Name	M.I.				
Address	City	State			Zip Code	
Phone	Date of E	Birth				
Reason test is needed						
Have you ever had a TB	Skin Test?	Yes	No			
2. Have you ever had a positive reaction to a TB Skin Test?			No	If yes, date of test Results		
3. Have you had any immunizations within the past six weeks?		Yes	No			
4. (Women only) If pregnant - have you discussed TB test with your doctor			Yes	No	N/A	
Mantoux Test. Date	Signature of Patient or Guardian	of Minor				
STEP 1	RECORD OF MANTO	UX TEST a	nd RES	BULTS		
Date	Date Read					
Time	Time Read					
TUBERSOL Lot #	Nurse Signature					
Site	Result		_			