



CONSENT FOR TUBERCULIN SKIN TEST

Last Name _____ First Name _____ M.I. _____ Physician _____

Address _____ City _____ State _____ Zip Code _____

Phone _____ Date of Birth _____

Reason test is needed _____

1. Have you ever had a TB Skin Test? Yes No
2. Have you ever had a positive reaction to a TB Skin Test? Yes 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

I have been informed that I am to return to the Massillon City Health Department on Thursday between 1:00 pm – 3:30 pm to have my skin test read.

By signing this form, I acknowledge that I have received a copy of the Notice of Privacy Practices from the Massillon City Health Department and I give the Massillon City Health Department permission to administer a Mantoux Test.

Date _____ Signature of Patient or Guardian of Minor _____

RECORD OF MANTOUX TEST

STEP 1

Date _____ Date Read _____ Result _____

Time _____ Time Read _____

TUBERSOL Lot # _____ Nurse Signature _____

Site _____ Given by _____