*[Replace this text with your organization’s identifier.]*

PARENT/GUARDIAN CONSENT FORM IGRA

Your child has been identified as having had exposure to tuberculosis (TB). The ***[county name]*** Health Department is providing TB testing ***[free of charge, include only if true]*** for those identified as having had close contact to someone with active TB disease. The TB test will be an Interferon Gamma Release Assay (IGRA) blood test that shows whether a person has been infected with tuberculosis bacteria. The test requires a blood draw with a result usually provided within ***[insert #days]***. If the test result is positive, additional medical evaluation may be needed to rule out active TB disease.

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| **PLEASE NOTE: Students will not be tested without a signed consent form. Please fill out the portion below, sign, and return with the completed Health Questionnaire on *[date].*** |

**PLEASE CHECK ONE OF THE BOXES BELOW** for the IGRA TB blood test:

❑ I consent to TB testing of my child by ***[insert county name]*** by means of an IGRA blood test. I understand that a TB blood test may need to be repeated *(*8-10 weeks after last contact) and I give consent for a second test if indicated.

***[If X-ray services will be provided]*** I consent for my child to receive a chest x-ray to rule out tuberculosis disease if needed.

**OR**

❑ My child should not be tested now because of a documented positive TB test result in the past.

Date of the TB skin test: \_\_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ Result: \_\_\_\_\_mm

Date of positive TB blood test (IGRA): \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_

Doctor/medical provider:

Address:

Telephone:

***[If X-ray services will be provided]*** I consent for my child to receive a chest x-ray to rule out active tuberculosis disease.

### OR

❑ I will have my child tested to rule out TB infection/disease by our own doctor and will provide ***[county name]*** County Public Health Department with documentation of the results by ***[date]*.**

Doctor/medical provider:

Address:

Telephone:

**Regardless of whether or not you have consented to services, please provide the following information:**

Name of Child (print): Date of Birth:

Home Address:

Telephone (day): Telephone (evening/cell/message):

CONSENT/AUTHORIZATION

Name of Parent or Guardian (print):

**Signature of Parent or Guardian**  Date:

**COMPLETE THIS CONSENT FORM AND HEALTH QUESTIONNAIRE**

**SEND BOTH WITH YOUR CHILD ON THE DATE OF THE SCREENING *[add testing date(s)]***

For questions about this form, please call ***[county name]*** County Public Health Department at ***[phone number]***.