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

ADULT/STAFF CONSENT FORM

Tuberculin Skin Test (TST)

The Mantoux tuberculin skin test (commonly known as the TB skin test) shows whether a person has been infected with tuberculosis (TB). If the test is positive, additional tests are needed to determine if you have latent TB infection or active TB disease. You will **NOT BE CHARGED** for these services provided by the ***[county name]*** County Public Health Department.

|  |
| --- |
| **You cannot be tested without your consent and signature. Please fill out the portion below, sign, and return with the Health Questionnaire on *[date].*** |

**PLEASE CHECK ONE OF THE BOXES BELOW** for the TB skin test and chest x-ray:

❑ I consent to TB testing by the ***[county name]*** County Public Health Department, Tuberculosis Control Program, by means of a TB skin test. I will be examined two to three days later to determine if I have been infected with TB bacteria. I understand that a TB skin test may need to be repeated (8-10 weeks after last contact), and I give consent for a second test if needed.

I consent to receive a chest x-ray to rule out active TB disease if needed.

### OR

❑ I have had a documented positive TB skin test reaction/positive TB blood test in the past.

Date of the TB skin test: \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_ Results: in mm

Doctor/medical provider: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to receive a chest x-ray to rule out active TB disease.

### OR

❑ I will be tested by my own health provider to rule out TB infection/disease and will provide ***[county name]*** County Public Health Department with documentation of the results by ***[Replace with appropriate date]***

Doctor/medical provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Whether or not you have consented to services, please provide the following information:**

Name (print): Date of Birth:

Home Address:

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

CONSENT/AUTHORIZATION – This consent is valid through .

**Signature**  Date:

**COMPLETE AND RETURN THIS FORM AND HEALTH QUESTIONNAIRE ON *[DATE].***

**You cannot be tested without this consent.**

**Please return this form even if you do not consent to testing.**

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