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

PARENT/GUARDIAN CONSENT FORM TST

Your child has been identified as having had exposure to tuberculosis (TB). The ***[county name]*** Health Department is providing Mantoux tuberculin skin testing, also known as the TB skin test (TST), free of charge for those identified as having had close contact to someone with active TB disease. The TST must be read by staff from the ***[county name]*** Health Department within 48-72 hours after placing the TST to determine whether a person has been infected with tuberculosis (TB). If the TST is positive, additional medical evaluation may be needed to rule out active TB disease.

|  |
| --- |
| **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**

❑ I consent to TB testing of my child by the ***[insert county name]*** County Public Health Department staff by means of a TB skin test (TST). I understand that my child will have the site of the TST examined two to three days later to determine if they have been infected with TB bacteria. I understand that a TB skin test may need to be repeated within the next 8-10 weeks, 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 active TB disease if needed.

### OR

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

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

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

Doctor/ name of 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 within 10 days.

Doctor/name of 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 – This consent is valid through .

Name of Parent or Guardian (print):

**Signature of Parent or Guardian**  Date:

**COMPLETE AND RETURN THIS FORM AND HEALTH QUESTIONNAIRE WITH YOUR CHILD ON *[date].* Students cannot be tested without this consent.**

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

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