

Manitowoc County Health Department  
 1028 S 9<sup>th</sup> St.  
 Manitowoc, WI 54220  
 (920) 683-4155

<b>For Office Use</b>
PAID: Yes ~ No ~
NO CHARGE: ~
BILL TO: _____

## **TB SKIN TEST CONSENT RECORD**

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
 Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Race/Ethnicity \_\_\_\_\_  
 Physician \_\_\_\_\_

1. Have you had a previous skin test?  
 If yes, specify results: \_\_\_\_\_ mm\*
2. Have you ever had a blood test for tuberculosis?
3. Have you had a TB skin test within the last 5 years?
4. Have you ever been treated for TB? If yes, when, where, by whom:  
 \_\_\_\_\_  
 \_\_\_\_\_
5. Have you recently been exposed to someone with TB? If yes, when and by whom:  
 \_\_\_\_\_  
 \_\_\_\_\_
6. Have you been vaccinated with a live virus vaccine in the past four weeks?
7. Have you had any periods of unexplained illness? If yes, what?  
 \_\_\_\_\_  
 \_\_\_\_\_
8. Are you currently taking (or recently stopped taking) any corticosteroid or other immunosuppressive agents?
9. Has a physician or nurse informed you that you are infected with the Human Immunodeficiency Virus (HIV) or AIDS virus?
10. Have you had BCG (Tuberculosis) vaccine?\*\*\* If yes, how often and at what ages? \_\_\_\_\_
11. Can you return in 48-72 hours to have the test read?
12. Reason for testing today (if for employment purposes, indicate employer): \_\_\_\_\_

YES	NO
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	

**\* NOTE: IF THE REACTION WAS SIGNIFICANT, DO NOT REPEAT TEST.**


\*\*\* Not routinely given in U.S.A.

\_\_\_\_\_  
**SIGNATURE** of person to receive tuberculin skin test or person authorized to sign on behalf of the person who will receive requested tuberculin skin test.

\_\_\_\_\_  
**DATE**

**TB Skin Testing Short-Term Service and Consent Record (cont.)**

Tuberculin Test Record(s)

	MANTOUX	TWO-STEP MANTOUX
Test given?	Yes _____ No _____	Yes _____ No _____
	Date: _____ Time: _____ ____/____/____ ____:____	Date: _____ Time: _____ ____/____/____ ____:____
Antigen name, strength, amount	Tubersol / Aplisol 5TU / 0.1cc 0.1cc	Tubersol / Aplisol 5TU / 0.1cc 0.1cc
Site	LA / RA	LA / RA
Manufacturer	Sanofi Pasteur / JHP	Sanofi Pasteur / JHP
Lot Number		
Expiration Date		
Date Vial Opened		
RN Signature		
Date Read	Date: _____ Time: _____ ____/____/____ ____:____	Date: _____ Time: _____ ____/____/____ ____:____
Results (mm)		
RN Signature		

***Instructions / Education to Client:***

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**1028 S 9<sup>th</sup> St**  
**Manitowoc, WI 54220**  
**Ph: (920) 683-4155 / Fax: (920) 683-4156**  
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