OSAGE COUNTY HEALTH DEPARTMENT
1218 E Main St
Linn, MO 65051
(573) 897-3103

MANTOUX TUBERCULIN SKIN TEST
CONSENT FORM

Full Legal Name: _____

Date of Birth (Month/Day/Year): _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Declined to Specify | Race: ☐ White ☐ American Indian/Alaska Native ☐ Black/African American ☐ Asian/Pacific Islander ☐ Unknown ☐ Declined to Specify |

Ethnicity: ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Unknown ☐ Declined to Specify

School Name or Clinic Site: _____

Parent/Guardian (if applicable): _____

Patient Address: _____ City: _____

State: _____ Zip Code: _____ County: _____ Phone Number: _____

Please answer the following questions about tuberculin history:

Have you ever had a **positive** Mantoux tuberculin skin test (TST)?	☐ Yes	☐ No	☐ Unknown
Have you ever been vaccinated with BCG?	☐ Yes	☐ No	☐ Unknown
Have you ever had a positive Interferon Gamma Release Assay (IGRA) test?	☐ Yes	☐ No	☐ Unknown
Have you ever been diagnosed or treated for TB Disease?	☐ Yes	☐ No	☐ Unknown

Reason for testing:

☐ Contact to TB case ☐ School (specify program): _____

☐ Employment ☐ Other (please describe): _____

I consent to have the Osage County Health Department administer a Mantoux tuberculin skin test. I acknowledge that the potential risks and benefits of the services, as well as the risks associated of not participating in the service has been explained to me and all questions have been answered. I request and authorize Osage County Health Department to release healthcare information of the patient name above to appropriate healthcare entities, including physician, laboratory, etc. I understand that this test is deemed a self-pay procedure and any fees are my responsibility. I acknowledge that I have had the opportunity to review the Osage County Health Department's Notice of Privacy Practices and have been offered/given a copy. I have been informed that I am to **return to the Osage County Health Department within 48-72 hours** to have my Mantoux tuberculin skin test read. Failure to return within this time frame for reading will result in having another Mantoux tuberculin skin test placed and need for additional payment.

Signature: _____ (Circle: Self/Parent/Guardian/Designee)

Date: _____

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CLINICAL USE ONLY:

Name: _____ DOB: _____

☐ Paid Date Paid: _____ Staff Initials Accepting Payment: _____

Date & Time Administered	Site Administered	Manufacturer / NDC	Lot Number / Expiration Date
	Forearm	Sanofi Pasteur	
Signature of Vaccine Administrator	Date & Time Read	Result / Interpretation	Signature of Reader

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