

Tuberculosis/Mantoux Skin Testing Form

SECTION I: INFORMATION/CONSENT

Mycobacterium tuberculosis (TB) is a disease which is carried through the air in small particles when people, who have active TB cough, sneeze, speak, or sing. It usually affects the lungs but can also affect the heart, kidneys, bones, and other organs of the body. The TUBERCULOSIS SKIN TEST is a way of identifying TB infection. You cannot get TB from the skin test.

Side Effects: If you have been exposed to TB in the past, swelling and redness may develop at the site of the test. A blister or scar may also result.

Precautions: The TB skin test should not be given to persons who have had a positive reaction in the past, or who have had an active case of TB, or who have taken TB medications in the past. If this has happened to you, please tell the nurses prior to taking the skin test.

BCG: Since there is no reliable method of distinguishing tuberculin reactions caused by BCG (bacilli Calmette-Guerin) vaccine from those caused by natural infections, if you have received BCG vaccine (given in foreign countries) it is not a contraindication for receiving the TB skin test. The test should be given and interpreted routinely.

Pregnancy: Pregnancy is not a contraindication to receiving the tuberculin skin test (Source: MMWR, Vol. 43/No. RR-113, CDC, 10.28.94)

Results: Return to have your test read in 2 days. Failure to have the test read will necessitate repeating the test.

~If you have any questions or do not understand this information, please discuss this with the nurse now~

Consent: I (parent/guardian/self) have read and understand the above information on this form about tuberculosis skin testing. I (parent/guardian/self) give my consent to have the test administered to _____ (name of child; if applicable).

Name (parent/guardian/self) (print): _____ Signature: _____

SECTION II: RISK ASSESSMENT

Circle "Yes" or "No". Please complete this section

- 1. YES NO Have you ever had Tuberculosis? When? _____
2. YES NO Have you ever had a positive reaction to a TB skin test? When? _____
3. YES NO Has a Health Care Provider or Clinic ever advised you should not receive a TB skin test?
4. YES NO Have you ever been immunized against TB with BCG?
5. YES NO Have you received a MMR or Varicella vaccine in the last 30 days?
6. YES NO Have you had a known exposure to TB since your last TB test?
7. YES NO Have you ever had a TB skin test?

Do you have any of the following symptoms?

Table with 5 columns: YES, NO, Symptom, YES, NO, Symptom. Rows include: A persistent cough for longer than 2 weeks, Coughing up blood, Profuse night sweats, Recurring, dull, tightness or aching pain in chest.

TO THE BEST OF MY KNOWLEDGE, THE ABOVE ANSWERS ARE TRUE

Signature (parent/guardian/self): _____ Date: _____

SECTION III: PPD ADMINISTRATION

Name: _____ DOB: _____

Address: _____ Phone: _____

Date PPD Planted: _____ Site: (L) FA / (R) FA Administrator Signature: _____

Date PPD Read: _____ Results: _____ mm Negative / Positive Signature: _____

Date of CXR: _____ Results: _____ Medication Therapy: _____ Date Completed: _____

Manufacturer: Sanofi Pasteur Lot Number: _____ Expiration Date

