



Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Reason for TB Skin Test: _____

1. Have you ever had a previous tuberculin test? Yes No
 If Yes, When: _____ Where: _____ Skin test or Blood test: _____
 Have you ever had a positive test result? Yes No
2. Have you had any of the following within the past 4 to 6 weeks? Chickenpox vaccine, MMR(Measles, Mumps, Rubella) Vaccine, Shingles Vaccine or any live vaccines, corticosteroids, or specialized treatment for rheumatoid arthritis or Crohn's disease? Yes No
3. Have you experienced any of the following symptoms: Persistent cough, weight loss of 10 pounds or more in last month, lethargy, night sweats or coughing up blood? Yes No
4. Have you been diagnosed with an immunosuppressive medical condition, End stage renal disease, Hodgkins' disease, sarcoidosis, etc? Yes No
5. Have you recently had a bacterial disease or viral infection? Yes No
6. Do you have health insurance from an employer or privately? Yes No
7. Do you have Medicaid or insurance through Job and Family Services? Yes No

I hereby acknowledge I have been offered a copy of the Auglaize County Health Department's Notice of Privacy Practices. I understand this document provides information on how my health information may be disclosed by Auglaize County Health Department and my rights with respect to my information. I or person authorized to make the request (parent or guardian) give the Auglaize County Health Department permission to perform the Tuberculin skin test.

Signature: _____ Date: ____/____/____

*****OFFICE USE ONLY*****

Payment: _____ Check/ Cash/ CC

1-STEP: Tubersol Lot# _____ Mfg: Sanofi Pasteur Exp.Date _____
 Dosage: _____ Site of Test: _____ Route: Intradermal
 Date Given: _____ Time Given: _____ Given By: _____
 Date Read: _____ Time Read: _____ Results: _____ mm Read By: _____
 Adverse Effects: _____

2-STEP: Tubersol Lot# _____ Mfg: Sanofi Pasteur Exp.Date _____
 Dosage: _____ Site of Test: _____ Route: Intradermal
 Date Given: _____ Time Given: _____ Given By: _____
 Date Read: _____ Time Read: _____ Results: _____ mm Read By: _____
 Adverse Effects: _____

____ 1-Step Needed ____ 2-Step Needed
 Education and 2-Step Date Given _____
 (Initials)