

(UDOH, Bureau of Communicable Disease Control, TB Control 801-538-6096)

Consent for Tuberculin Skin Test *(Do not
get tested if you've tested positive in the past)*

Name: _____ DOB _____ Gender: M ___ F ___
Address: _____ Home phone: _____
_____ Work phone: _____

I understand that if I have an immunosuppressive condition, recent vaccine history, history of a previous positive PPD, or am sick now, I should discuss this with the test administrator before proceeding. I have had a chance to have my questions answered, and agree to be tested. I understand that I must return in 48 – 72 hours to have the test read, or it will need to be repeated.

Patient signature: _____ Today's Date: _____

.....

Clinic use
only

PPD manufacturer: _____ Lot # _____ Exp. Date _____ Site: _____

Placed by: _____
Print Name Signature Date

Reading: _____ mm Referred for further evaluation: Y ___ N ___

Read by: _____
Print Name Signature Date

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