



TB SKIN TEST FORM

Name: _____ DOB: _____ Age: _____

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

Phone: _____ Reason for TB Skin Test: _____

- 1. Have you ever had a reaction to a previous tuberculin test (skin test or blood test)? Yes No
2. Have you had any of the following live vaccines within the past 4 to 6 weeks? Yes No
3. Have you ever had a BCG vaccine? Yes No
4. Are you currently taking any oral or IV steroid medication including cortisone? Yes No
5. Are you currently experiencing any of the following symptoms: 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.

Signature: _____ Date ____/____/____

OFFICE USE ONLY

Payment: _____ Check/ Cash/ CC ____ 1-Step Needed ____ 2-Step Needed

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