TB TEST CONSENT FORM

Bring form to first class – do not mail in

All students will provide evidence of the healthcare requirements as stated in the Student Handbook. Evidence may be in the form of a copy of immunization records, copies of medical reports or a statement by their Primary Physician verifying dates and that the health care requirements have been met. If not records are available, request the IMMUNIZATION DECLARATION FORM from Primary Instructor. All medical reports will be confidentially maintained by the Primary Instructor.

*Students will provide the date of the last TB skin test or quantiferon gold test **or may be done during class by the Primary Instructor for a $10 charge**. If greater than 12 months, a two step is required. Completion of testing must be done prior to clinical. For known positive TB skin test or quantiferon gold, evidence of a negative baseline chest x-ray at or within one year of starting their initial clinical experience is required **AND** an annual TB questionnaire.*

Release for T. B. Mantoux test

I, ____________________________________ understand that it is my responsibility to inform the nurse administering this test if I have ever had a positive reaction to a T.B. test in the past. No further T. B. Mantoux tests will be given to me and I will provide a recent negative chest x-ray report. I understand that if I were to develop signs and symptoms of weakness, night sweats, and persistent cough during the course and clinical experience, I would inform the Primary Instructor, who will request a chest X-ray to be taken at my cost.
I understand that I am unable to be in the clinical area until testing has been read as negative.

Female Staff Only: If you believe that you may be pregnant, consult your physician prior to receiving the T. B. Mantoux test.

I understand that it is my responsibility to notify my Physician prior to taking this test. I do not hold WISCONSIN C.N.A. TRAINING CENTER LLC responsible if I should consent to the test, for any adverse effects on a fetus, or myself, in the event of death, deformity or abnormality.

I have read all of the above and consent to the T. B. Mantoux test

Signature:____ Date _________________

Parental or Guardian consent for minors

Signature:____ Date _________________

Record of T.B. Mantoux test

Date Given/Initials	Site	Lot #-exp. Date	Date Read/Initials	Result in mm/Initials

Follow up recommended if positive test:

Record of initials:

Office use only

Verification of Health Care Requirements

TB test date within 12 mo	Verification obtained		

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