TUBERCULIN TESTING FORM

Auglaize County Health Department
prevent. promote. protect.

813 Defiance St. Wapakoneta, Ohio 45895
(phone) 419-738-3410/ (fax) 419-738-7818

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? COVID 19 mRNA vaccine, 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:____

02/02/2021

s/Brenda /Communicable Disease/TB/TB forms

____1-Step Needed____2-Step Needed
Education and 2-Step Date Given______