St. John's Military School
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CONSENT FOR ADMINISTRATION OF TUBERCULIN SKIN TEST

Cadet Name ____

Date of Birth ____

Please answer the following questions as if they apply at this moment

Has your cadet ever had a positive TB test?	Yes	No
Has your cadet been exposed to a person with known or suspected tuberculosis?	Yes	No
Has your cadet had a persistent cough lasting longer than 2 weeks?	Yes	No
Has your cadet experienced pain in the chest, coughing, up blood or sputum?	Yes	No
Has your cadet experienced weakness or fatigue?	Yes	No
Has your cadet experienced an unexplained weight loss or loss of appetite?	Yes	No
Has your cadet experienced chills, fever, or night sweats?	Yes	No

I give my consent for my cadet to receive the Mantoux/PPD Tuberculin Test. I understand that the Tuberculin Test is **mandatory** and being administered to aid in detection of tuberculosis infection. I understand that a positive reaction to the test may occur if cadet has been exposed to the tuberculosis disease and will not hold St. John's Military School or administering staff responsible if a positive reaction occurs despite correct administration of injection.

My Cadet is authorized to receive the Mantoux/PPD Tuberculin Test and booster if indicated:

____
(Parent or Guardian Signature)

OR

Due to a documented past positive Mantoux/PPD results I have been advised not to be tested and have provided documentation of a negative chest x-ray report to SJMS School Nurse.

My cadet us unable to receive tuberculin testing

____
(Parent or Guardian Signature)

OR

I deny my consent for my cadet to receive the Mantoux/PPD Tuberculin Test due to medical or religious exemption with documentation of stated exemption provided to the SJMS School Nurse. I understand that by refusing the Mantoux/PPD Tuberculin Test I will not provide monitoring of health status during enrollment at St. John's Military School, possibly enabling the spread of the tuberculosis disease to my cadet and /or others.

I refuse for my cadet to receive the Mantoux/PPD Tuberculin Test

____
(Parent or Guardian Signature)

This portion to be completed by nurse

1. Tuberculin Purified Protein Derivative (Mantoux) Tubersol Lot # __________ Exp. Date __________________
2. Tuberculin Purified Protein Derivative (Mantoux) Tubersol Lot # __________ Exp. Date __________________

Only if booster indicated

	Date/Time of Test	**Date/Time of Test Read**	**Result**
Mantoux/PPD			mm induration
Booster indicated			mm induration
CXR indicated			

Nurse Signature	Date Given	Nurses Signature	Date Read