ST JOHN'S MILITARY SCHOOL

SJMS.ORG
P.O. BOX 5020
SALINA, KS 67402-5020
785•823•7231
fax 785•823•2701

CONSENT FOR ADMINISTRATION OF TUBERCULIN SKIN TEST

Cadet Name _____Date _____

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 that my cadet not to be tested and have provided documentation of a negative chest x-ray report to SJMS School Nurse.

My cadet is 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 incur the expense for my cadet to have a chest x-ray in order to ensure no active TB.

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