Montgomery County Government
OCCUPATIONAL MEDICAL SERVICES
255 ROCKVILLE PIKE, SUITE 125
ROCKVILLE, MARYLAND 20850
(240) 777-5118- PHONE
(240) 777-5132- FAX

Tuberculin Skin Test

Patient Consent Statement: I certify that I have read the information on this form. I have had an opportunity to ask related questions and my questions were answered to my satisfaction. I believe that I understand the benefits and risks of taking a tuberculin test and I assume the risks. I request that the tuberculin test be given.

Name_____ Date of Birth_____

Address_____

County Job Title_____ Social Security Number_____

Have you ever tested positive to a tuberculin skin test in the past?_____If yes, when?_____

If yes, what treatment was given to you at the time?_____

Signature of person to receive test_____ Date_____

For Clinic Use Only

Test # 1
Skin Test PPD 5TU 0.1 ml Lot #_____ Manufacturer_____
Expiration Date_____

Date Given_____ Right Forearm / Left Forearm (Circle One)

Date Read_____ Result_____mm

Signature/Title of Person Giving Test_____

Signatue/Title of Reader_____

Test # 2
Skin Test PPD 5TU 0.1 ml Lot #_____ Manufacturer_____
Expiration Date_____

Date Given_____ Right Forearm / Left Forearm (Circle One)

Date Read_____ Result_____mm

Signature/Title of Person Giving Test_____

Signature/Title of Reader_____

If history of positive skin test review checklist given_____