



**VOLUNTEER/CHAPERONE TB SCREENING FORM**

<b>Name (Last, First, Middle Initial)</b>	<b>DOB</b>
<b>Signature</b>	<b>Date</b>

*I hereby give my consent to have a Mantoux skin test. I certify that the following information is true.*

<b>Have you ever or currently have any of the following (check yes or no):</b>	<b>Yes</b>	<b>No</b>
1. Medicine for TB or for a positive skin test (Medical documentation required)	<input type="checkbox"/>	<input type="checkbox"/>
2. Recent immunization for measles, mumps, or rubella in the last 30 days	<input type="checkbox"/>	<input type="checkbox"/>
3. BCG vaccination If yes, when?	<input type="checkbox"/>	<input type="checkbox"/>
4. Known exposure to someone with TB If yes, when?	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
6. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
7. Lung problems	<input type="checkbox"/>	<input type="checkbox"/>
8. Treatment with cancer medicines	<input type="checkbox"/>	<input type="checkbox"/>
9. Steroids or cortisone	<input type="checkbox"/>	<input type="checkbox"/>
10. Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
11. Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
12. Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
13. Blood in sputum	<input type="checkbox"/>	<input type="checkbox"/>
14. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
15. Weight loss	<input type="checkbox"/>	<input type="checkbox"/>
16. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
17. Allergies? (Please list)	<input type="checkbox"/>	<input type="checkbox"/>
18. Currently taking medication? (Please list)	<input type="checkbox"/>	<input type="checkbox"/>

**Skin Test**

Date Given:	Reading:	Read Date:
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**Chest X-Ray**

The patient had a chest X-ray on Date: \_\_\_\_\_ and is determined to be free of infectious tuberculosis.

Healthcare Provider Signature & Stamp: \_\_\_\_\_