PRINT Download Clear Form

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
COMMUNICABLE DISEASE CONTROL SECTION

TUBERCULIN TEST (PPD)

Last Name | First Name | M.I. | DOB | Age

Address | Ethnic Group

I, the undersigned, do hereby give my full consent to the Department of Public Health and Social Services to perform the test for the maintenance of my good health.

Signature of person to receive the test or person authorized to make the request.

Date:_____

CLINIC
DATE TESTED
MANUFACTURER & LOT NO.
SITE OF INJECTION
DATE READ / RESULTS

DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
COMMUNICABLE DISEASE CONTROL SECTION

TUBERCULIN TEST (PPD)

Last Name | First Name | M.I. | DOB | Age

Address | Ethnic Group

I, the undersigned, do hereby give my full consent to the Department of Public Health and Social Services to perform the test for the maintenance of my good health.

Signature of person to receive the test or person authorized to make the request.

Date:_____

CLINIC
DATE TESTED
MANUFACTURER & LOT NO.
SITE OF INJECTION
DATE READ / RESULTS