



Public Health
 Prevent. Promote. Protect.
 Page County Public Health
 1208 W. Nishna Rd., Suite B
 712-246-2332

**TB MANTOUX PPD METHOD
 CONSENT FORM**

Date Given:		Date Read:	
Manufacturer		NEGATIVE (mm)	
Lot #		POSITIVE (mm) *	
Site of Injection			
Administrator		Results Read by	

Full Name: _____ Age: _____

Birth date: _____ Soc Sec: _____ Phone: _____

Address: _____

City: _____ Zip Code: _____ County: _____

Physician: _____ City: _____
 (a copy of your results will be sent to your physician)

Allergies: _____ Alt Phone: _____

Signature _____ Date _____

* NOTES: _____

OFFICE USE:

Pay Source: _____ PP _____ or _____ Business to Bill: _____

Patient name: _____

Date of birth: ____/____/____
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If a question is not clear, please ask your health care provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have allergies to medications, food, or any vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction after receiving a vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had x-ray treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past year, have you received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____

Did you bring your immunization record card with you? yes no

It is important for you to have a personal record of your vaccinations. If you don't have a record card; ask your health care provider to give you one! Bring this record with you every time you seek medical care. Make sure your health care provider records all your vaccinations on it.

www.immunize.org/catg.d/p4065scr.pdf • Item#P4065 (4/04)