Request and Consent For Tuberculin 2-Step Skin Test To Be Administered by St. Joseph Home and Release of Liability

I acknowledge the Tuberculin Skin Test is required at St. Joseph Home. If I have not consulted my physician, I know and understand that I have a right to do so and have been encouraged to consult with my physician by St. Joseph Home. I am requesting of my own free will without duress that St. Joseph Home administer this skin test. I am acting on my own free will and voluntary decision.

By executing this form, I agree to release **St. Joseph Home**, its owners, officers, staff, employees, representatives, and agents from any and all liability which may be directly or indirectly traceable to my consent and request to participate in the skin test program. By executing this form, I agree that no person or entity, including but not limited to, myself, my executor or administrator shall commence any form of legal or administrative proceedings for damages or otherwise, against one or more of the aforementioned parties.

____ __________________________________
Employee/Consultant Signature Date

TEST MUST BE READ 48 - 72 HOURS AFTER DATE GIVEN

If there is a positive result, the Employee must report to HR to be sent for a chest x-ray before working with any resident.

Name: ________________________________ PPD Due: ______________

Department: ____________________________ Shift: ____________

STEP 1:

Date Given: _______ Arm: _____________ Nurse: _____________ LPN___ RN___

Date Read: _______ Results: ________mm Nurse: _____________LPN___ RN___

STEP 2: (2nd step must be given within 7-21 days after 1st step is administered)

Date Given: _______ Arm: _____________ Nurse: _____________ LPN___ RN___

Date Read: _______ Results: ________mm Nurse: _____________LPN___ RN___

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MUST BE COMPLETED BY EMPLOYEE AT THE TIME OF TB TEST:

Have you had any of the following in the past year:

Fatigue, weakness, chest pain: ___yes ___no
Anorexia, unexplained weight loss: ___yes ___no
Night sweats, low grade fever: ___yes ___no
Unexplained productive cough for 2-3 weeks: ___yes ___no
Spitting up blood (hemoptysis): ___yes ___no

____ __________________________________
Employee/Consultant Signature Date

Please return this form to the Human Resources Department. Thank you.