COVINA-VALLEY
UNIFIED SCHOOL DISTRICT

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District Superintendent
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VOLUNTEER/CHAPERONE TB SCREENING HISTORY

Name (Last, First, Middle Initial)	**DOB**
Signature	**Date**

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

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

Skin Test

Date Given:	Reading:	Read Date:

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: _____