MARION COUNTY HEALTH DEPARTMENT

Marion County Children Services

Please provide the following information in order to receive your TB Test.
Your test will need to be read 48-72 hours afterward in order to be complete.

PLEASE PRINT:

NAME: LAST	FIRST	MIDDLE	SEX M F	DATE of BIRTH	AGE

ADDRESS: STREET	CITY	COUNTY	STATE	ZIP CODE	RACE

HOME TELEPHONE # _____

SOCIAL SECURITY # _____

PRIMARY CARE PHYSICIAN: _____

Signature of person receiving TB Test:

This signature gives permission for the TB Test to be administered and also authorizes the Marion County Health Dept. to release the results of your TB Test to Marion County Children Services, 1680 Marion-Waldo Rd., Marion OH 43302.

This signature further acknowledges that you have been given/offered a copy of the most recent version of Marion County Heath Dept's Notice of Privacy Practice. If you have any questions, please ask a member of staff or contact the Privacy Compliance Officer.

X _____ Date: _____

OFFICE USE ONLY

Date of Test_____ Injection Site _____ Nurse's Signature _____

Date Read _____ Results _____ Nurse's Signature _____