



# Adult vaccination/blood test consent form for BCG & skin test

Please complete all the white boxes.

Date of first appointment (dd/mm/yyyy)

First name

Surname

Male

Female

Date of birth (dd/mm/yyyy)

Address

Post code

Contact number

Alternative

GP name

GP address

Post code

GP contact number

### Medical history:

- 1. Have you ever had a vaccination against Tuberculosis (BCG) or a recent skin test?  Yes  No
- 2. In the last 3 months, have you received a high dose of steroid therapy or any other immunosuppressant medication?  Yes  No
- 3. Have you been treated for leukaemia or malignant disease?  Yes  No
- 4. Is there any known HIV infection?  Yes  No
- 5. Have you ever been treated for tuberculosis or currently receiving TB treatment?  Yes  No
- 6. In the last 3 weeks, have you had a severe viral infection?  Yes  No
- 7. In the last 3 months, have you had any infection needing antibiotics?  Yes  No
- 8. In the last 3 months, have you had any injection or blood transfusion?  Yes  No
- 9. Have you ever had an adverse reaction to any immunisation?  Yes  No
- 10. Are you suffering from a generalised skin infection or infected eczema?  Yes  No
- 11. Do you have any known allergies to the vaccine components?  Yes  No
- 12. Have you travelled overseas?  Yes  No

*If yes, please list where.*

13. Have you had any known contact with TB?

Yes

No

14. Do you have any other medical conditions?

Yes

No

*If yes, please explain.*

15. *Women only* — Date of last menstrual cycle (dd/mm/yy):

*Vaccination will be postponed if your temperature is above 37.3 °C at consultation.  
BCG is not to be given during pregnancy.*

I (full name) \_\_\_\_\_ hereby consent to receive a blood or skin test and a BCG immunisation or referral to a chest clinic, whichever proves necessary.

Signature \_\_\_\_\_

Date \_\_\_\_\_

# BREAKSPEAR MEDICAL GROUP USE ONLY

## BCG Vaccination

Date	<input type="text"/>	Temperature	<input type="text"/>
Medical conditions	<input type="text"/>	Injection site	<input type="text"/>
General Health on day of vaccination	<input type="text"/>	Batch number	<input type="text"/>
Vaccine	<input type="text"/>	Dose	<input type="text"/>
Doctor's signature	<input type="text"/>	Exp date	<input type="text"/>
		Make	<input type="text"/>
		Nurse's signature	<input type="text"/>

## Mantoux Skin Test

Patient's name	<input type="text"/>	Temperature	<input type="text"/>
Batch number	<input type="text"/>	Date & time of skin test	<input type="text"/>
Manufacturer	<input type="text"/>	Exp date	<input type="text"/>
Injection site	<input type="text"/>	Dose & strength administered	<input type="text"/>
Date to be read	<input type="text"/>	Date and time test read	<input type="text"/>
Results in mm	<input type="text"/>		
Adverse reactions	<input type="text"/>		
Any blistering present	<input type="text"/>		
Any ulceration present	<input type="text"/>		
BCG required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Referral required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Doctor's signature	<input type="text"/>	Nurse's signature	<input type="text"/>

## TB Blood Test

Patient's name	<input type="text"/>	Date & time of blood test	<input type="text"/>
Date of birth	<input type="text"/>	Results	<input type="text"/>
General condition	<input type="text"/>	Referral	<input type="text"/>
Doctor's signature	<input type="text"/>	Nurse's signature	<input type="text"/>

Notes