Declination of Tuberculosis Testing

The Flathead City-County Health Department has recommended that my child receive tuberculosis (TB) testing in order to protect my child from the development of active TB.

I acknowledge that I am aware of the following facts:

1. My child has been identified as a close contact of an active TB case.
2. TB testing is recommended for all persons who have identified close contact (those that were in close proximity in a shared space with the student) with an active TB case.
3. TB bacteria can attack any part of the body such as the kidney, spine, and brain.
4. If not treated properly, TB disease can be fatal.
5. TB is treatable and preventable.
6. If my child develops any symptoms consistent with TB (cough of longer than three weeks, unexplained weight loss, night sweats, chills, fever and coughing up blood) they will be excluded from school until symptoms end or TB testing occurs.

Despite these facts, I am choosing to decline TB testing at this time.

I understand that I may change my mind at any time and accept this testing; however, the delay in testing may result in progression of the disease.

I have read and fully understand the information on this declination form.

Child’s Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3/2018