



## Parental Permission for Tuberculosis Screening

I give permission for my son/daughter, \_\_\_\_\_,  
(print name of your child)

to participate in the Tuberculosis (TB) Screening. The TB screening consists of two PPD (Purified Protein Derivative) skin tests administered at a minimum two-week interval. The test must be repeated each year as long as your son/daughter continues to volunteer at Jupiter Medical Center.

I understand further that if my son/daughter is not able to tolerate a PPD skin test or has a positive test, a chest X-ray may be required. I understand that there is no charge for these tests.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name