West Virginia Department of Health
Tuberculosis Elimination Program (WV TBEP)

PARENTAL REFUSAL OF ISONIAZID TREATMENT FOR CHILD WHO IS A HIGH-RISK CONTACT OF TUBERCULOSIS INFECTION

Your child has been identified as a high-risk contact of someone infected with tuberculosis. As explained to you earlier, once infected with the TB bacteria, children are more likely to get sick with TB disease and can become sick much more quickly than adults. Infants and young children are especially at risk because they are more likely than older children and adults to develop life-threatening forms of TB disease like TB meningitis, which can cause irreversible brain damage and/or death.

The physician has prescribed a course of preventive treatment with isoniazid (INH) or another approved LTBI treatment for your child as recommended by the Centers for Disease Control and Prevention (CDC). Treatment prevents TB disease in most individuals who complete the recommended regimen course. It is very important anyone being treated for TB finish the treatment regimen and take the drugs exactly as instructed. If medication is started and then stopped, it increases the child's risk of developing a form of resistant TB which is much harder and takes much longer to treat.

The medication and the appropriate nursing supervision would be provided to you at no cost.

Without preventive treatment, the risk of your child getting sick from TB is very high. For recently infected individuals and others at high risk for disease, that risk is greater than any risk associated with preventive treatment.

I have read the information on this form about preventive therapy for my child. I believe I understand the benefits and risks of taking preventive therapy. I have had an opportunity to ask questions which were answered to my satisfaction.

The Health Department has offered to provide me with medication and nursing supervision in order to decrease my child's risk for developing tuberculosis disease. However, I have chosen not to let my child take the medication as recommended. If I should change my mind and allow my child to take the medication, I understand that the Health Department will be available to advise me on this matter.

NAME OF PATIENT (PRINT):	PATIENT'S BIRTH DATE:
PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP):	COUNTY:
SIGNATURE OF PARENT, GUARDIAN OR OTHER AUTHORIZED PERSON REFUSING TREATMENT:	DATE:
PRINTED NAME OF PARENT, GUARDIAN OR OTHER AUTHORIZED PERSON REFUSING TREATMENT:	RELATIONSHIP TO THE CHILD:
WITNESS NAME (PRINT):	
WITNESS SIGNATURE:	DATE:

Local Health Department: _____

Address: _____ Telephone: _____