TUBERCULOSIS RISK ASSESSMENT FOR ALL NEW STUDENTS

NAME: __________________________ GRADE/SCHOOL: __________________

PARENT/GUARDIAN: ______________ DATE: ______________

The United States Public Health Services and the Center for Disease Control and Prevention recommends that tuberculosis (TB) skin testing be performed on all individuals who may be at increased risk of TB. Please complete the following form.

1. Was the student born in a country outside of the United States?
   ____ No    ____ Yes What country? ______________________

2. Has the student spent three or more consecutive months in a foreign country in the last five years?
   ____ No    ____ Yes What country? ______________________

3. Has the student been exposed or had contact with a person with active TB in the last year?
   ____ No    ____ Yes Whom? _____________________________

4. Was the student homeless or did he/she live in a shelter during the last two years?
   ____ No    ____ Yes

5. Does the student have any of the following: persistent cough, coughed up blood, fever for more than one week, unexplained weight loss or HIV infection?
   ____ No    ____ Yes

6. Is the student currently taking oral steroid medications (other than inhalers), or cancer treating drugs?
   ____ No    ____ Yes

7. Has the student ever had a positive TB skin test or taken any treatment for TB disease or a positive TB test?
   ____ No    ____ Yes If yes please give results and dates: ______________

8. Does the student have any of the following medical conditions?
   a. Diabetes    No Yes
   b. Malnutrition No Yes
   c. Cancer      No Yes
   d. Chronic renal failure No Yes
   e. Congenital or acquired Immunodeficiency No Yes

INSTRUCTIONS FOR THE HEALTH CARE PROVIDER: Please complete the following when the risk assessment contains positive (yes) answers.

Date: __________ PPD Provided: No: __________ Yes: __________
     Results in millimeters: __________________
     CXR Provided: No____ Yes____ Results: ______________
     Treatment provided: ______________________

Name Of Health Care Provider: ___________________________________________
Address:  ___________________________________________________________
Telephone: ___________________________________________________________
Signature: ____________________________________________________________

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