UNIVERSITY HIGH SCHOOL

Student Name: _____ **Date of Birth:** _____

Tuberculosis (TB) Risk Assessment for School Entry

1.	Was your child born in Africa, Asia, Latin America, or Eastern Europe?	☐ **Yes** ☐ **No**
2.	Has your child traveled to a country with a high TB rate (30 days or longer)?	☐ **Yes** ☐ **No**
3.	Has your child been exposed to anyone with TB disease?	☐ **Yes** ☐ **No**
4.	Has a family member or someone your child has been in contact with had a positive TB test or received medications for TB?	☐ **Yes** ☐ **No**
5.	Was a parent, household member, or someone your child has been in close contact with traveled to a country with a high TB rate?	☐ **Yes** ☐ **No**
6.	Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	☐ **Yes** ☐ **No**
7.	Has the child been exposed to a person who: Is currently in jail or who has been in jail in the past 5 years, has HIV, is homeless, lives in a group home, uses illegal drugs, is a migrant farm worker?	☐ **Yes** ☐ **No**
8.	Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	☐ **Yes** ☐ **No**

Parent Signature: _____ **Date:** _____

If you answered NO to all the above questions, this form is complete and there is no need to proceed.
If you answered YES to any of the above questions, the below physician's clearance is needed or proof of a negative TB test result with in the last calendar year.

Physician's Clearance:

Tuberculin Skin Test (TST/Mantoux/PPD) Date given: Date read:	Induration _____ mm Impression: ☐ Negative ☐ Positive
Interferon Gamma Release Assay (IGRA) Date:	Impression: ☐ Negative ☐ Positive ☐ Indeterminate
Chest X-Ray (**required with positive TST or IGRA)** Date:	Impression: ☐ Negative ☐ Abnormal finding

☐ Child has **no** TB symptoms, none of the above or other risk factors for TB and does not require a TB test.
☐ Child has a risk factor but has been evaluated for TB and is free of active TB disease.

_____ _____
Health Provider Signature, Title **Date**

Name/Title of Health Provider: _____ **Phone Number:** _____

Facility/Address: _____ **Fax Number:** _____