

Tuberculosis (TB) Risk Assessment and Symptom Evaluation Form

Baseline Individual TB Risk Assessment:

** Considered at increased risk for TB if any of the following statements are marked "Yes" and should have TB testing performed.*

Temporary or permanent residence (for greater than 1 month) in a country with a high TB rate. Yes No

This includes any country OTHER THAN the U.S., Canada, Australia, New Zealand, and those in Northern and Western Europe

If "Yes" list country: _____

If "Yes" list date(s) of exposure: _____

Current or planned immunosuppression. Yes No

This includes human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication.

Close contact with someone who has had infectious TB disease since the last TB test or screen. Yes No

Employee in high risk setting (correctional facility or homeless shelter). Yes No

If "Yes" list facility: _____

TB Symptoms Evaluation and Prior Treatment:

Do you currently have, or have had in the past 12 months, any of the following signs or symptoms:

| | | |
|-------------------------------------|-----|----|
| Cough lasting 3 weeks or longer | Yes | No |
| Coughing up blood (hemoptysis) | Yes | No |
| Pain in the chest | Yes | No |
| Persistent shortness of breath | Yes | No |
| Unexplained weakness or fatigue | Yes | No |
| Unexplained weight loss | Yes | No |
| No appetite | Yes | No |
| Fever or chills for no known reason | Yes | No |
| Night sweats for no known reason | Yes | No |

Prior History of TB Treatment Yes No

If "Yes" was treatment for: *(circle one)*

Active TB Latent TB unsure

Date of treatment (if known): _____

Previous BCG Vaccine Yes No

If "Yes" date (if known): _____

By signing below, I am stating that the above information is correct/accurate. If I am concerned that I have been exposed to or developed symptoms of TB, I will notify CHC/SEK as soon as possible.

| | |
|------------------------------|---|
| _____ Parent Signature | ____/____/____ Date (Month/Day/Year) |
| _____ Parent Printed Name | _____ Student Name |

| | |
|----------------------------|---------|
| <i>Internal Use Only:</i> | |
| TST performed | |
| Date: | Result: |
| IGRA test performed | |
| Date: | Result: |
| CXR performed | |
| Date: | Result: |