SCHOOL HEALTH SERVICES

TUBERCULOSIS SCREENING ASSESSMENT

Student _____ Date of Birth _____ Grade __

Parent/Guardian_____

HAS CHILD OR ANY FAMILY MEMBER……	YES	NO
1. Been in contact with someone known or suspected of having tuberculosis?	___	___
2. Been exposed to someone with an undiagnosed chronic (prolonged) cough?	___	___
3. Traveled to Asia, Middle East, Latin America or Africa or been in contact with someone who has?	___	___
4. Been exposed to someone who is HIV infected?	___	___
5. Been exposed to someone who has been in : __ jail __ nursing home __ hospital __group home	___	___
6. Do you know of any tuberculosis cases that have been discovered in your neighborhood?	___	___
7. Have you moved here from a developing country or been in contact with someone who has?	___	___

Parent/guardian _____ Date _____

For nursing staff use:
Medical evaluation required ___Yes ___ No

If yes, referred to _____
Evaluation/Testing to be completed by _____

School Nurse _____ Date _____

Health Room Assistant _____ Date _____