SCHOOL HEALTH SERVICES & TUBERCULOSIS SCREENING ASSESSMENT

Student's Full Name: _____ Date of Birth: _____ *(mm/dd/yyyy)*

Parent/Guardian Full Name: _____ Student's Grade: _____

HAS CHILD OR ANY FAMILY MEMBER...

Been in contact with someone known or suspected of having tuberculosis? YES _____ NO _____

Been exposed to someone with an undiagnosed chronic (prolonged) cough? YES _____ NO _____

Traveled to Asia, Middle East, Latin America or Africa or been in contact with someone who has? YES _____ NO _____

Regularly visit someone living in a major city? YES _____ NO _____

Been exposed to someone who is HIV infected? YES _____ NO _____

Been exposed to someone who has been in jail or an institution such as a hospital, nursing home, group home, etc.? YES ___ NO___

Do you know of any tuberculosis cases that have been discovered in your neighborhood? YES _____ NO _____

Have you moved here from a developing country or been in contact with someone who has? YES _____ NO _____

Name of Student's Doctor: _____ Phone: _____

Preferred Hospital: _____

Medication(s) to be dispensed at school: _____

_____

Permission for Medication: A doctor's note is required for all prescription medication. A doctor's note is required for all over the counter medication other than those listed below.

The school nurse may administer: Acetaminophen (generic Tylenol) YES _____ NO _____

Ibuprofen (generic Advil) YES _____ NO _____

Benadryl for allergic reaction YES _____ NO _____

Parent/Guardian Signature: _____ Date: _____

FOR NURSING STAFF USE

Medical evaluation required? YES _____ NO _____

If yes, referred to _____

Evaluation/Testing to be completed by _____