Screening Created by PD 16 School Health TEAM

## TUBERCULOSIS RISK ASSESSMENT FOR ALL NEW STUDENTS - CONFIDENTIAL

**NAME**: _____ **GRADE/SCHOOL**: _____

**PARENT/GUARDIAN**: _____ **DATE**: _____

The United States Public Health Service and the Centers for Disease Control and Prevention (CDC) recommend that tuberculosis (TB) 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 If yes, what country? _____
2. Has the student spent three or more consecutive months in a foreign country in the last five years?
   ☐ No ☐ Yes If yes, what country? _____
3. Has the student been exposed to or had contact with a person with active TB in the last year?
   ☐ No ☐ Yes If yes, who? _____
4. Was the student homeless/incarcerated 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 If yes, please explain: _____
6. Is the student currently taking oral steroid medication (other than inhalers), cancer treating drugs or any other medication that might weaken his/her immune system?
   ☐ No ☐ Yes If yes, please explain: _____
7. Has the student ever had a positive test for TB or been treated for active TB disease or latent TB infection?
   ☐ No ☐ Yes If yes, please provide details: _____
   _____
   _____
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
   f. Gastrectomy ☐ No ☐ Yes
   g. Silicosis ☐ No ☐ Yes

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**INSTRUCTIONS FOR HEALTHCARE PROVIDER: Please complete the following when the risk assessment contains one or more positive (yes) answers. Return to the school nurse.**

Date of TB test: _____ -Type of TB Test: TB skin test **OR** IGRA (interferon gamma release assay)

Test result: _____ mm induration (for TST) **OR** IGRA result: Positive ☐ Negative ☐ Indeterminate ☐

CXR ordered? No ☐ Yes ☐ -If yes, result: _____

Treatment provided? No ☐ Yes ☐ -If yes, what? _____

Name of Health Care Provider (please print): _____

Address: _____

Telephone: _____

Signature: _____

Revised March 2015

## SCHOOL BOARD POLICY FOR TUBERCULOSIS SCREENING REQUIREMENTS

I. Students entering school for the first time or returning after three months outside the United States must provide documentation from a licensed physician, nurse practitioner, physician assistant or registered nurse prior to entry of a:

A. TB Risk Assessment documenting low risk for TB disease. All answers on the Risk Assessment should be negative. BCG vaccination does not exclude student from following protocol. **– OR –**

B. Documentation of a negative TB (Mantoux) skin test or interferon gamma release assay within the past 12 months or after exposure. **– OR –**

C. Written documentation of having successfully completed treatment for active tuberculosis disease.

II. Students shall be excluded from school until the TB policy requirement is met. As part of the risk assessment and targeted screening process, questions arise concerning the definition "high prevalence country" for the purposes of completing the risk assessment tool and determining who should receive a test for tuberculosis (either a tuberculin skin test (TST) or interferon gamma release assay (IGRA).