TUBERCULOSIS RISK ASSESSMENT for all New Students

Students entering Spotsylvania County Schools for the first time
(all Pre-K, Kindergarten, and any transfer students entering grades Pre-K-12) and all
new students must undergo a TB screening prior to enrollment.

Student’s Name: __________________________________________________________________________
School: _______________________________________ Grade: _________________
Parent/Guardian: _________________________________________________________________________

I. Student Health History:  (to be completed by student’s parent / guardian)

A. Was the student born in a country outside of the United States? _____ No _____ Yes If yes, what country?
   __________________________________________________________
B. Has the student spent three or more consecutive months in a foreign country in the last five years? _____ No
   _____ Yes If Yes, what country?
C. Has the student been exposed or had contact with a person with active TB in the last year? _____ No
   _____ Yes If Yes, whom?
D. Was the student homeless or did he/she live in a shelter during the last two
   years? _____ No _____ Yes
E. 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
F. Is the student currently taking oral steroid medications (other than inhalers), or cancer
   treating drugs? _____ No _____ Yes
G. Has the student ever had a positive TB skin test or taken any treatment for Tuberculosis disease or a positive
   TB test? _____ No _____ Yes If yes, please give results and dates: _________________________________________
H. Does the student have any of the following medical conditions?
   1. Diabetes No Yes (circle one)
   2. Malnutrition No Yes (circle one)
   3. Cancer No Yes (circle one)
   4. Chronic renal failure No Yes (circle one)
   5. Congenital or acquired immunodeficiency No Yes (circle one)

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Parent Certification

I certify that the answers given above are accurate and factual to the best of my knowledge.
_____________________________________________ Date: _______________________
   (signature of parent/guardian)

INSTRUCTIONS FOR THE HEALTH CARE PROVIDER: Please complete the following when the risk assessment contains yes answers

Date: _______ PPD Provided: No: _____ Yes: _____ Results in millimeters:
   ______________________ Chest x-ray provided: No: _____ Yes: _____ Treatment
   provided: No: _____ Yes: ______

Name of Health Care Provider: _____________________________________________________________________ Signature: _______________________
Address: _____________________________________________________________________________________
Telephone#: ________________________________

Legal reference: Spotsylvania County Board Regulation: JHCC-R3, Code of Virginia: Section 22.1-272

“GREAT STUDENTS DESERVE QUALITY SCHOOLS”