Child's Name: _____ Birthdate: _____ Male/Female School: _____
Last, First month/day/year

Address_____ Phone: _____ Grade: _____
Street City Zip

Santa Clara County Public Health Department
TB Risk Assessment for School Entry

This form must be completed by a licensed health professional and returned to the child's school.

1. Was your child born in Africa, Asia, Latin America, or Eastern Europe?	❑ Yes ❑ No
2. Has your child traveled to a country with a high TB rate* (for more than a week)?	❑ Yes ❑ No
3. Has your child been exposed to anyone with tuberculosis (TB) disease?	❑ Yes ❑ No
4. Has a family member or someone your child has been in contact with had a positive TB test or received medications for TB?	❑ Yes ❑ No
5. Was a parent, household member or someone your child has been in close contact with, born in or traveled to a country with a high TB rate?*	❑ Yes ❑ No
6. Has another risk factor for TB (i.e. one of those listed on the back of this page)?	❑ Yes ❑ No

* This includes countries in Africa, Asia, Latin America or Eastern Europe. For travel, the risk of TB exposure is higher if a child stayed with friends or family members for a cumulative total of 1 week or more.

If YES, to any of the above, the child has an increased risk of TB infection and should have a TST/ IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results below.

Tuberculin Skin Test (TST/Mantoux/PPD) Date given: Date read:	Induration _____ mm Impression: ❑ Negative ❑ Positive
Interferon Gamma Release Assay (IGRA) Date:	Impression: ❑ Negative ❑ Positive ❑ Indeterminate
Chest X-Ray (**required with positive TST or IGRA**) Date:	Impression: ❑ Normal ❑ Abnormal finding
☐ LTBI treatment (Rx & start date):	☐ Prior TB/LTBI treatment (Rx & duration):
☐ Contraindications to INH or rifampin for LTBI	☐ Offered but refused LTBI treatment

Providers, please check one of the boxes below and sign:

☐ Child has no TB symptoms, none of the above or other risk factors for TB and does not require a TB test.

☐ Child has a risk factor, has been evaluated for TB and is free of active TB disease.

_____ _____
Health Provider Signature, Title **Date**

Name/Title of Health Provider:

Facility/Address:

Phone number: **Fax number:**