California School Tuberculosis (TB) Risk Assessment Questionnaire

Use of this questionnaire is required by California Education Code Sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555. DOB: _____ Student ID: _____ Have you had a positive TB Test? \Box Yes \Box No Have you had a history of treatment for active TB disease or treatment for latent TB infection? □ Yes □ No Where?____ If yes, when? _____ Name of Medication(s): ______ Number of Months Taken: _____ SYMPTOM ASSESSMENT: Date: _____ Do you currently have a persistent cough or hoarseness? ☐ Yes ☐ No Do you have "Night Sweats"? ☐ Yes ☐ No Do you have a persistent low-grade fever? ☐ Yes ☐ No Have you had unexpected weight loss? ☐ Yes ☐ No Were you born in a country outside of the USA, Canada, Australia, New Zealand, or Western & Northern Europe? ☐ Yes ☐ No If yes, what country? Have you lived in or traveled to a country outside of the USA, Canada, Australia, New Zealand, or Western & Northern Europe, with an elevated TB rate, for at least 1 month? ☐ Yes ☐ No If yes, what country? _____ Have you had close contact with someone who has infectious TB? ☐ Yes ☐ No Date: Student Signature: YOUR MEDICAL PROVIDER MUST REVIEW AND SIGN THIS FORM PRIOR TO SUBMISSION. STUDENTS ANSWERING "YES" TO ANY SCREENING QUESTIONS ABOVE SHOULD UNDERGO EITHER SKIN OR BLOOD TESTING FOR TB INFECTION. Type of Test (Please circle one option): Skin Test / Blood Test Date of Testing: _____ Results from TB Testing:

Negative Positive Action Taken if positive result: ______ Date: _____ Medical Provider Signature (required): _____ Provider Printed Name/Stamp: _____ Medical License #: _____ Healthcare Provider Comments/Recommendations: