California School Employee 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.

Name: _____ DOB: _____ Student ID: _____

Have you had a positive TB Test? ☐ Yes ☐ No

Have you had a history of treatment for active TB disease or treatment for latent TB infection? ☐ Yes ☐ No

If yes, when? _____ Where? _____

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

Student Signature: _____ Date: _____

YOUR MEDICAL PROVIDER MUST REVIEW AND SIGN THIS FORM PRIOR TO SUBMISSION.

********** FOR PROVIDER USE ONLY **********

STUDENTS ANSWERING "YES" TO ANY SCREENING QUESTIONS ABOVE SHOULD UNDERGO EITHER SKIN OR BLOOD TESTING FOR TB INFECTION.

Date of Testing: _____ Type of Test (Please circle one option): Skin Test / Blood Test

Results from TB Testing: ☐ Negative ☐ Positive Action Taken if positive result: _____

Medical Provider Signature (required): _____ Date: _____

Provider Printed Name/Stamp: _____ Medical License #: _____

Healthcare Provider Comments/Recommendations:

_____

_____

_____