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.

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: ____

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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:

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