TUBERCULOSIS SCREENING FOR SCHOOL CHILDREN

Recommended Screening Tool from the Medical Advisory Board of the
Massachusetts Committee for the Elimination of Tuberculosis

STUDENT: _____ **DATE:** _____

SCHOOL: _____ **GRADE:** _____

To help determine if your child needs to be skin tested for Tuberculosis (TB), please answer the following questions. If you answer YES to any questions, please see below*.

1 Was the child born in Africa, Asia (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East? ☐ YES ☐ NO

In what country was the child born? _____

2 Has the child lived or traveled in Africa, Asia (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month? ☐ YES ☐ NO

3 Has the child lived with or spent time with someone who has been sick with TB in the last 2 years? ☐ YES ☐ NO

5 Have any members of the child's household come to the United States from another country? ☐ YES ☐ NO

6 Does the child have any history of immunosuppressive disease or take any medications that might cause immunosuppression? ☐ YES ☐ NO

My answers to the questions above provide an accurate profile of my child's risk for tuberculosis.

Parent/Guardian Signature: _____ **DATE:** _____

***If you answered YES to any of the above questions, your child must receive a PPD skin test prior to the admission to school, unless there is written documentation of a previous positive TB test (TST or IGRA). Please take this form to your child's physical exam and have it completed by your physician and return to the School Nurse.**

CHILD'S NAME: _____

PPD DATE RECEIVED: _____ **DATE READ:** _____ **RESULT:** _____

PHYSICIAN'S NAME: _____

PHYSICIAN'S SIGNATURE: _____