16261 Richmond Turnpike
Bowling Green, VA
22427-2203

TUBERCULOSIS RISK ASSESSMENT FOR ALL NEW STUDENTS

NAME: _____ **GRADE/SCHOOL**: _____

PARENT/GUARDIAN: _____ **DATE**: _____

The United States Public Health Service and the Centers for Disease Control and Prevention (CDC) recommend that tuberculosis (TB) testing be performed on all individuals who may be at increased risk of TB. Please complete the following form.

1. Was the student born in a country outside of the United States?
   ☐ No ☐ Yes If yes, what country? _____
2. Has the student spent three or more consecutive months in a foreign country in the last five years?
   ☐ No ☐ Yes If yes, what country? _____
3. Has the student been exposed to or had contact with a person with active TB in the last year?
   ☐ No ☐ Yes If yes, who? _____
4. Was the student homeless/incarcerated or did he/she live in a shelter during the last two years?
   ☐ No ☐ Yes
5. Does the student have any of the following: persistent cough, coughed up blood, fever for more than one week, unexplained weight loss or HIV infection?
   ☐ No ☐ Yes If yes, please explain: _____
6. Is the student currently taking oral steroid medication (other than inhalers), cancer treating drugs or any other medication that might weaken his/her immune system?
   ☐ No ☐ Yes If yes, please explain: _____
7. Has the student ever had a positive test for TB or been treated for active TB disease or latent TB infection?
   ☐ No ☐ Yes If yes, please provide details: _____
   _____
   _____
8. Does the student have any of the following medical conditions?
   a. Diabetes ☐ No ☐ Yes
   b. Malnutrition ☐ No ☐ Yes
   c. Cancer ☐ No ☐ Yes
   d. Chronic renal failure ☐ No ☐ Yes
   e. Congenital or acquired Immunodeficiency ☐ No ☐ Yes
   f. Gastrectomy ☐ No ☐ Yes
   g. Silicosis ☐ No ☐ Yes

INSTRUCTIONS FOR HEALTHCARE PROVIDER: Please complete the following when the risk assessment contains positive (yes) answers.

Date of TB test: _____ -Type of TB Test: TB skin test **OR** IGRA (interferon gamma release assay)

Test result: _____ mm induration (for TST) **OR** IGRA result: Positive ☐ Negative ☐ Indeterminate ☐

CXR ordered? No ☐ Yes ☐ -If yes, result: _____

Treatment provided? No ☐ Yes ☐ -If yes, what? _____

Name of Health Care Provider (please print): _____

Address: _____

Telephone: _____

Signature: _____