THE HAGEDORN LITTLE VILLAGE SCHOOL

Jack Joel Center for Special Children

Tuberculosis Screening and Risk Assessment

NAME: _____ **DATE:** _____

1. Have you EVER spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia and New Zealand.
   a. YES I have been in a foreign country for ≥ 30 days (not including those listed above).
   b. NO I have not been in any country for ≥ 30 days (except the ones listed above).

2. Have you had close contact with anyone who had active TB since your last TB test?
   YES / NO

3. Do you currently have any of the following symptoms:
   a. YES / NO unexplained fever for more than 3 weeks
   b. YES / NO cough for more than 3 weeks with sputum production
   c. YES / NO bloody sputum
   d. YES / NO unintended weight loss ≥ 10 pounds
   e. YES / NO drenching night sweats
   f. YES / NO unexplained fatigue for more than 3 weeks

4. Have you ever been diagnosed with active TB disease?
   YES / NO

5. Have you ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB?
   a. YES one or more of these is true for me
   b. NO none of these is true for me

6. Have you ever been treated with medication for TB *or* for a positive TB test (eg, taken "INH")?
   YES / NO
   IF YES, what year, with which medication, for how long, and did you complete the treatment course? _____

7. Do you have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health Provider.)
   YES one or more of these is true for me
   NO none of these is true for me

   Comments: _____
   _____

Completed and reviewed by Occupational Health Provider (MD, NP, PA, RN)

NAME: _____

SIGNATURE: _____