Child's Name: _____ **Birthdate:** _____ **Male/Female** **School:** _____
Last, First month/day/year

Address _____ **Phone:** **Grade:** _____
_____ **Street** **City** **Zip**

Yuba County Public Health

Tuberculosis (TB) Risk Assessment for School Entry

This form must be completed by a licensed health professional in the U.S. and returned to the child's school.

1. Was your child born in, resided, or traveled (for more than one month) to a country with an elevated rate of TB*? ❑ **Yes** ❑ **No**

2. Has your child been in close contact to anyone with TB disease in their lifetime? ❑ **Yes** ❑ **No**

3. Is your child immunosuppressed; current, or planned? (e.g., due to HIV infection, organ transplant, treatment with TNF-alpha antagonist or high-dose systemic steroids (e.g., prednisone ≥ 15 mg/day for ≥ 2 weeks). ❑ **Yes** ❑ **No**

*Most countries other than the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe. This does not include tourist travel for <1 month (i.e., travel that does not involve visiting family or friends, or involve significant contact with the local population).

If YES, to any of the above questions, the child has an increased risk of TB and should have a TB blood test or a tuberculin skin test (TST) unless there is either 1) a documented prior positive IGRA or TST or 2) no new risk factors since last documented negative IGRA (performed at age ≥2 years in US or TST performed at age ≥ 6 months in U.S.)

All children with a current or prior positive IGRA/TST result must have a medical evaluation, including a chest x-ray (CXR; posterior-anterior and lateral for children <5 years old is recommended). CXR is not required for children with documented prior treatment for TB disease, documented prior treatment for latent TB infection, or BCG-vaccinated children who have a positive TST and negative IGRA. If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI) to prevent progression to TB disease.

Enter test results for all children with a positive risk assessment:

Date of (IGRA)	Result: ❑ Negative ❑ Positive ❑ Indeterminate
Tuberculin Skin Test (TST/Mantoux/PPD) Date placed: Date read:	Induration_____mm Result: ❑ Negative ❑ Positive
Chest X-Ray Date: _	Impression: ❑ Normal ❑ Abnormal
LTBI Treatment Start Date: _____ ☐ Rifampin daily - 4 months ☐ Isoniazid/Rifapentine - weekly X 12 weeks ☐ Isoniazid daily - 9 months ☐ Isoniazid and Rifampin daily - 3 months	☐ Prior TB/LTBI treatment (Rx & duration): _____ ☐ Treatment medically contraindicated ☐ Declined against medical advice

Please check one of the boxes below and sign:

☐ Child has no TB symptoms, no risk factors for TB, and does not require a TB test.
☐ Child has a risk factor, has been evaluated for TB and is free of active TB disease.
☐ Child has no new risk factors since last negative IGRA/TST and has no symptoms.
☐ Child has no TB symptoms. Appointment for IGRA/TST scheduled on:_____.
☐

_____
Health Care Provider Signature, Title Date

Name/Title of Health Provider:
Facility/Address:
Phone number: