**Rappahannock Area Health District**
**608 Jackson Street**
**Fredericksburg, VA 22401**
**Office (540) 899-4797**
**FAX (540) 899-4599**

# TUBERCULOSIS RISK ASSESSMENT FOR ALL NEW STUDENTS

NAME: ________________________ GRADE/SCHOOL: ________________

PARENT/GUARDIAN: __________________ DATE: ________________________

The United States Public Health Services and the Center for Disease Control and Prevention recommends that tuberculosis (TB) skin 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 What country? ___________________
2. Has the student spent three or more consecutive months in a foreign country in the last five years?
   ____ No ____ Yes What country? ____________________
3. Has the student been exposed or had contact with a person with active TB in the last year?
   ____ No ____ Yes Whom? ________________________
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
6. Is the student currently taking oral steroid medications (other than inhalers), or cancer treating drugs?
   ____ No ____ Yes
7. Has the student ever had a positive TB skin test or taken any treatment for TB disease or a positive TB test?
   ____ No ____ Yes If yes please give results and dates: _____________
8. Does the student have any of the following medical conditions?

| | Condition | | | | Condition | | |
|---|---|---|---|---|---|---|---|
| a. | Diabetes | No | Yes | | f. Gastrectomy | No | Yes |
| b. | Malnutrition | No | Yes | | g. Silicosis | No | Yes |
| c. | Cancer | No | Yes | | h. Blood Disorder | No | Yes |
| d. | Chronic renal failure | No | Yes | | | | |
| e. | Congenital or acquired Immunodeficiency | No | Yes | | | | |

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**INSTRUCTIONS FOR THE HEALTH CARE PROVIDER: Please complete the following when the risk assessment contains positive (yes) answers.**

Date: _________

Test for TB infection: No: ___ Yes: ___
TST Reading in millimeters: ________ Or IGRA Result: ________
CXR Provided: No____ Yes____ Results: ______________
Treatment provided: ______________________________

Name of Health Care Provider: __________________________________
Address: _____________________________________________________
Telephone: ___________________________________________________
Signature: ____________________________________________________