DELAWARE DEPARTMENT OF EDUCATION

Tuberculosis (TB) Risk Assessment Questionnaire for Students

Prior to use of this form, the school nurse must review the student's health record and assure that the student is compliant with the requirements for a current health examination (within past 2 years) and up-to-date immunizations. The questionnaire must be administered by the school nurse to the parent/guardian in person, or by phone, and signed by the person who answered the questions.

Name: ____
Last First MI

Date of Birth: ___/___/___ Date form completed: ___/___/___

1. Has your child had close contact with anyone with an active infectious TB disease? ___Yes___No
2. Was any household member, including your child, born in or has he/she traveled to area(s) where TB is common? (Refer to the TB-Endemic Countries List provided by the Delaware Division of Public Health) ___Yes ___No
3. Does your child have regular (i.e., daily) contact with adults at high risk for TB? (i.e., those who are HIV infected, homeless, incarcerated, and/or illicit drug users) ___Yes ___No
4. Does your child have any health condition or take medication that might affect his/her immune system? ___Yes ___No
5. Has your child ever had a positive test for tuberculosis? ___Yes ___No

Any "yes" response to questions 1-4 is considered a positive risk factor and is an indication for administering a Mantoux tuberculin skin test or TB blood test, such as The Quantiferon Gold Test, to the child.

A "yes" response to question 5 indicates probable previous exposure to TB, and requires medical follow-up to evaluate medical status.

This child has been screened by his/her school nurse for risk of exposure to tuberculosis. Based upon the results of the TB Risk Assessment Questionnaire the child,

□ Does **NOT** require a Tuberculosis Test

□ **Does** require a Tuberculosis Test

□ **Does** require documentation related to current disease status

TB testing and documentation must be completed and given to the school nurse by ___/___/___ (date) or your child will be excluded from school.

School Nurse Comments: ____

____

School Nurse (Signature) ____

I give permission for the school nurse and my child primary care physician (name of physician) ______________________________ *to share information relating to this form.*

Parent/Guardian (Signature) ____