

TB Screening and History for Students with Prior Positive Tuberculin Skin Tests or IGRAs

Name: First: _____ Last: _____

Date of Birth (month/day/year): ____/____/____ Age: _____ M F

Race: _____ Country of Birth: _____

1. HISTORY

Tuberculin skin test (TST): Date: ____/____/____ Result: _____ mm of induration Negative Positive

IGRA: Date: ____/____/____ Result: _____ Negative Positive Indeterminate

Last chest x-ray: Date: ____/____/____ Result: _____

Has your child ever been diagnosed with tuberculosis?	Yes	No	
Has your child ever taken medications for tuberculosis disease?	Yes	No	If "Yes," to either question, please list medications and dates if available: _____ _____ _____ _____ Was all medication taken? If no, why not? _____
Has your child ever taken medications because of a positive TB skin test?	Yes	No	

2. SYMPTOMS

Does your child have any of these symptoms?			
Fever	Yes	No	
Heavy sweats at night	Yes	No	
Loss of weight (unintentional)	Yes	No	If "Yes," _____ lbs/kgs since ____/____/____
Fatigue	Yes	No	
Cough	Yes	No	If "Yes," started ____/____/____
Productive cough	Yes	No	
Bloody cough	Yes	No	
<ul style="list-style-type: none"> If the family answers "YES" to any of the questions in 2. SYMPTOMS, the child should be referred for evaluation and chest x-ray if needed. If all responses are "NO", no further action is needed. Child may be cleared for school. 			

School Nurse

____/____/____
Date