San Ysidro School District
TUBERCULOSIS RISK ASSESSMENT FORM

Student's Name:_____ Birthdate:_____ Date:_____

School:_____ Teacher:_____ Special Ed: Yes ☐ No ☐

The safety and well-being of your child is important to us. Tuberculosis is a disease that can cause serious illness and/or death. Completion of this tuberculosis screening form is required prior to your child's entry into school.

HISTORY:(Please put a check mark in the appropriate box next to each statement.)

YES	NO	If there are any YES answers (except #1) the TESTING section must be completed by the health care provider.
		1. Did your child ever receive BCG?
		2. Does your child have any of the following risk factors?
		a. Recent close contact with someone with active infectious TB disease.
		b. Immunosuppressed – HIV/AIDS, organ transplant or on immunosuppressant medication.
		c. History of abnormal chest x-ray suggestive of TB disease.
		d. Lived in or travelled to a high risk area: Africa, Asia, Eastern Europe or Central or South America.
		e. Other high risk conditions: IV drug use, chronic kidney disease, cancer, diabetes, malabsorption or GI bypass.
		3. Does your child have any signs or symptoms of active TB disease? – cough more than 3 weeks, chest pain, unexplained weight loss, fevers, night sweats
		4. Has your child ever had a positive Tuberculin skin test?
		5. Has your child ever been treated for latent tuberculosis? Medication: start date: completion date:
		a. If yes, confirm with a blood test b. Or confirm with a chest x-ray.

TESTING (THIS SECTION FOR DOCTOR/HEALTH CARE PROVIDER AND SCHOOL STAFF):

1. **Tuberculin skin test (TST) (≥5mm. is positive if yes to 2a, b or c above; otherwise ≥10mm. is positive)**
   Date given: _____ Date read: _____ Interpretation: negative ☐ positive ☐

   Result: _____ mm. induration TST results must be recorded as millimeters (mm) induration. If no induration, write 0.

   ☐ **Parent was unable to provide documentation of follow-up chest x-ray and treatment.**

2. **TB blood test (Interferon Gamma Release Assay-IGRA) – May be done instead of TST: recommended if history of positive TST or BCG vaccination.**
   Result: negative ☐ positive ☐ intermediate ☐ Date obtained: _____

3. **Chest x-ray (required if TST or IGRA is positive)**
   Result: normal ☐ abnormal (ANY abnormal findings) ☐ Date of Chest x-ray: _____

4. **Any other findings: _____**

   _____

Provider Name: _____ Signature: _____ Date: _____
(Print/Type)

SHS (Rev. 12/17)