SUBMIT AT TIME OF REGISTRATION

Name of Child_____

School _____ Date _____

TB Questionnaire

Tuberculosis (TB) is a disease caused by TB germs and is transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever chills, and night sweats.

A person can have TB germs in their body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is available to use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis. All information obtained herein will be kept in strict confidence.

	Yes	No
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around any adult with these symptoms or problems? has your child had any of these symptoms or problems? has your child been around anyone sick with TB?		
Was your child born in or has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, which country/countries?		
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infested, in jail or prison or recently came to the United States from another country?		

Has your child been recently tested for TB? Yes _____(if yes, specify date _____/_____) No____
Has your child ever had a positive TB skin test Yes _____(if yes, specify date _____/_____) No____

_____ _____
Signature of Parent/Guardian Date

For school/healthcare provider use only.

PPD administered Yes_____ No_____
If yes,
Date administered ____/____/____ Date read ____/_____/_____ Result of PPD test _____mm response

Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____
Signature Printed Name

Provider phone number_____

City_____ County_____

If positive, referral to healthcare provider Yes_____ No_____

If yes, name of provider _____

Does this child need follow up? Yes_____ No_____

If yes, when?_____