

Child's Name: _____ Birthdate: _____ Male/Female School: _____
Last, First month/day/year

Address _____ Phone: _____ Grade: _____
Street City Zip

Santa Clara County Public Health Department Tuberculosis (TB) Risk Assessment for School Entry

This form must be completed by a U.S. licensed primary care provider and returned to the child's school.

1. Was your child born in, or has your child resided in or traveled to (for more than one week) a country with an elevated TB rate?* Yes No
2. Has your child been exposed to anyone with TB disease? Yes No
3. Has a family member had a positive TB test or received medications for TB? Yes No
4. Was a parent, household member, or visitor who stayed in the child's home for >1 week, born in a country with an elevated TB rate?* Yes No
5. Is your child immunosuppressed [e.g. due to HIV infection, organ transplant, treatment with TNF-alpha inhibitor or high-dose systemic steroids (e.g. prednisone ≥ 15 mg/day for ≥ 2 weeks)]. Yes No

*Most countries other than the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe. This does not include tourist travel for <1 month (i.e. travel that does not involve visiting family or friends, or involve significant contact with the local population).

If **YES**, to any of the above questions, the child has an increased risk of TB and should have a TB blood test (IGRA, i.e. QuantiFERON or T-SPOT.TB) or a tuberculin skin test (TST) unless there is either 1) a documented prior positive IGRA or TST performed in the U.S. or 2) no new risk factors since last documented negative IGRA (performed at age ≥2 years in the U.S.) or TST (performed at age ≥6 months in the U.S.).

All children with a current or prior positive IGRA/TST result must have a medical evaluation, including a chest x-ray (CXR; posterior-anterior and lateral for children <5 years old is recommended). CXR is not required for children with documented prior treatment for TB disease, documented prior treatment for latent TB infection, or BCG-vaccinated children who have a positive TST and negative IGRA. If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI) to prevent progression to TB disease.

Enter test results for all children with a positive risk assessment:

Interferon Gamma Release Assay (IGRA)	
Date: _____	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Tuberculin Skin Test (TST/Mantoux/PPD)	Induration _____ mm
Date placed: _____ Date read: _____	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive
Chest X-Ray Date: _____ Impression: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	
LTBI Treatment Start Date: _____	<input type="checkbox"/> Prior TB/LTBI treatment (Rx & duration): _____
<input type="checkbox"/> Rifampin daily - 4 months	<input type="checkbox"/> Treatment medically contraindicated: _____
<input type="checkbox"/> Isoniazid/rifapentine - weekly X 12 weeks	
<input type="checkbox"/> Isoniazid daily - 9 months	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Declined against medical advice
<p>Please check one of the boxes below and sign:</p> <input type="checkbox"/> Child has no TB symptoms, no risk factors for TB, and does not require a TB test. <input type="checkbox"/> Child has a risk factor, has been evaluated for TB and is free of active TB disease. <input type="checkbox"/> Child has no new risk factors since last negative IGRA/TST and no TB symptoms.	
<div style="border-top: 1px solid black; width: 100%; margin-bottom: 5px;"></div> <div style="display: flex; justify-content: space-between;"> Health Care Provider Signature, Title Date </div>	

Name/Title of Health Provider: _____

Facility/Address: _____

Phone number: _____