TUBERCULOSIS PREVENTION AND CONTROL

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Recommended Screening Tool for school children from the Medical Advisory Board of Massachusetts Committee for the Elimination of Tuberculosis

Date:______________________

Name:____ **D.O.B.:**____________________

Dear Parent/Guardian:

To help your child's Health Care Provider determine if your child needs to be skin tested for TB, please answer the following questions:

	YES	**NO**
**Has your child lived with or spent time with anyone who possibly or definitely had tuberculosis or had a "positive" skin test for tuberculosis?	_____	_____
**Has anyone living in the household come to the United States from another country?	_____	_____
**Has your child traveled to (or) lived in another country for more than a month?	_____	_____

HAS YOUR CHILD LIVED WITH OR SPENT TIME WITH ADULTS WHO:

**Were homeless, living either on the street or in a shelter?	_____	_____
**Have AIDS or are HIV-infected?	_____	_____
**Used intravenous drugs or street drugs?	_____	_____
**Lived in a correctional facility, or mental institution?	_____	_____

My answers to the questions above provide an accurate profile of my child's risk for tuberculosis.

Parent/Guardian Signature:___________________________________ **Date:**_______________

Please submit this questionnaire to the Physician for evaluation

Physician Statement:____

Signature:____ **Date:**_______________

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