ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE – Initial Assessment[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner, school nurse or registered nurse).

Volunteer Name: _____ Date of Risk Assessment: _____

Volunteer BUSD Work Location: _____ Volunteer Job Title: _____

History of positive TB test or TB disease Yes ☐ No ☐ Date of Birth: _____ Social Security #: XXX-XX-_____
Last Four Digits

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.
If no, continue with questions below.

If there is a "Yes" response to any of the questions 1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.[2]	Yes ☐ No ☐
2. Close contact with someone with infectious TB disease	Yes ☐ No ☐
3. Birth in high TB-prevalence country** (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
4. Travel to high TB-prevalence country** for more than 1 month (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes ☐ No ☐

I certify that all statements made on this assessment questionnaire are true and complete to the best of my knowledge. I understand that false statements and incomplete information may subject me to disqualification or dismissal as a volunteer of the Burbank Unified School District.

_____
Volunteer's Signature

Office Use Only

1. Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.
2. Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013.

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

CERTIFICATE OF COMPLETION

To be signed by the licensed health care provider (physician, physician assistant, nurse practitioner or, when applicable, school nurse) completing the risk assessment and/or examination.

Volunteer Name: _____ **Completion Date:** _____
Please Print Clearly

Volunteer Job Title: _____ **Date of Birth:** _____

Volunteer Work Location: _____ **Social Security #: XXX-XX-**_____
Last Four Digits

The above-named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

_____
Health Care Provider Signature **License Number**

_____
Please Print Health Care Provider Name **Title**

_____
Office Address: **Street** **City** **State** **Zip Code**

_____
Telephone **Fax**

For Office Use Only
_____
_____
_____

Effective January 1, 2015 TBRA-I 2015-04-01