This form is to be completed if Tb test / low risk assessment is NOT noted on physician office form.

_____ _____

Name Date of Birth

CHILDREN WHO SHOULD BE TESTED FOR TUBERCULOSIS

A child who has been infected with tuberculosis (TB) may show no outward symptoms. However, infection can later lead to severe illness. To detect the problem before a child becomes ill, we perform a tuberculosis skin test.

Instead of testing all children, as we have in the past, we recommend that only some children should have a skin test. If a test is warranted, the child will be tested with the Intermediate PPD (Mantoux) skin test, because it is the most accurate available. We no longer recommend the use of the less accurate multiple puncture skin test, such as the Tine or Monovac.

To help your child's health care provider determine if your child needs to be skin tested, please answer the following questions.

• Has your child lived or spent time with anyone who possibly or definitely had tuberculosis or had a "positive" skin test for tuberculosis?	YES	NO
• Did you (parent or guardian), your child, or anyone else in your household come to the United States from another country?	YES	NO
• Has your child traveled to or lived in another country for more than a month? **(if the answer is yes a student must have a documented Tb test upon returning)**	YES	NO
Has your child lived with or spent time with adults who:		
• Were homeless, either living on the street or in a shelter?	YES	NO
• Used intravenous drugs or other street drugs?	YES	NO
• Lived in a correctional facility, nursing home, or mental health institution?	YES	NO

If your child has had a positive skin test for tuberculosis in the past, inform your child's health care provider. Your child will not need another test.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CHILD'S NEED FOR A TUBERCULOSIS SKIN TEST, PLEASE ASK YOUR CHILD'S HEALTH CARE PROVIDER!

THIS FORM HAS TO BE COMPLETED AND SIGNED AT THE DOCTOR'S OFFICE BY A HEALTH CARE PROFESSIONAL***NOT TO BE COMPLETED/SIGNED BY PARENT OR GUARDIAN**

_____ _____

Provider's Signature (MD/PA/NP) Date of Assessment

CCHS Nurse's fax number 978-683-5325