



**Secondary Registration Check-Off List**  
**Lista de verificación de Registración para Secundaria**

Name of Student: \_\_\_\_\_

Nombre del estudiante:

School of Residence: \_\_\_\_\_

Escuela de residencia:

Grade: \_\_\_\_\_

Grado:

**Completed Student Enrollment Packet includes:**

El paquete completo de inscripción de estudiantes incluye:

	Parent Check Off	School Check Off
1. Online Enrollment Confirmation (printed) Confirmación de inscripción en línea (impresa)	_____	_____
2. Birth Certificate or Passport (or other proof of age including age affidavit) Acta de nacimiento o pasaporte (u otra prueba de edad, incluida la declaración jurada de edad)	_____	_____
3. Proof of Immunizations Prueba de inmunizaciones	_____	_____
4. TB(PPD) Test (if coming from outside Santa Clara County): <i>*must be signed/stamped by physician</i> Prueba de TB (PPD) (si proviene de fuera del Condado de Santa Clara: <i>* debe estar firmado / sellado por un médico</i> )	_____	_____
5. Residency verification (1 of the following, dated in last 30 days) Verificación de residencia (1 de los siguientes, con fecha de los últimos 30 días)	_____	_____
<input type="checkbox"/> Utility bill/Factura de servicios <input type="checkbox"/> Copy of your lease agreement/rental agreement/escrow paperwork/ Copia de su contrato de arrendamiento / Contrato de alquiler / papeleo de depósito en garantía <input type="checkbox"/> Property tax payment receipt/Recibo de pago del impuesto a la propiedad <input type="checkbox"/> Pay Stub/Talon de pago <input type="checkbox"/> Voter registration or correspondence from a government agency/Registro de votantes o correspondencia de una agencia gubernamental <input type="checkbox"/> Affidavit of residency/Declaración jurada de residencia	_____	_____
6. Migrant Survey/ Encuesta de migrantes	_____	_____
7. Parent/Guardian Photo ID/Identificación con foto del padre/tutor	_____	_____
8. IEP (if applicable)/ IEP (si el estudiante tiene uno)	_____	_____
9. Transcript for students entering grades 10 - 12 Transcripción para estudiantes que ingresan a los grados 10 a 12	_____	_____

***\*If enrolling for current school year, please provide withdrawal form with exit grades from previous school***

***\* Si se inscribe para el año escolar actual, proporcione un formulario de retiro con las calificaciones de salida de la escuela anterior***

**For Office Use Only**

Assigned School: \_\_\_\_\_ Aeries ID #: \_\_\_\_\_ McKinney Vento: Yes / No (circle)

Previous School: \_\_\_\_\_ Leave Date: \_\_\_\_\_

Entered into Aeries by: \_\_\_\_\_ Date: \_\_\_\_\_ Medical Considerations: \_\_\_\_\_

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 licensed health professional in the U.S. and returned to the child's school.**

1. Was your child born in, resided, or traveled (for more than one month) to a country with an elevated rate of TB\*?  Yes  No
2. Has your child been in close contact to anyone with tuberculosis (TB) disease in their lifetime?  Yes  No
3. Is your child immunosuppressed; current, or planned? (e.g., due to HIV infection, organ transplant, treatment with TNF-alpha antagonist 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.

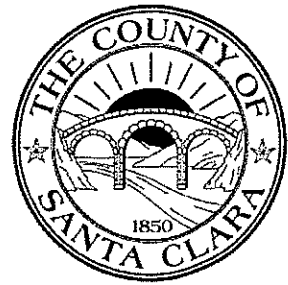
**Enter test results for all children with a positive risk assessment:**

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) Date placed: _____ Date read: _____	Induration _____ mm 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"/> Rifampin daily - 4 months <input type="checkbox"/> Isoniazid/Rifapentine - weekly X 12 weeks <input type="checkbox"/> Isoniazid daily - 9 months <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Prior TB/LTBI treatment (Rx & duration): _____ <input type="checkbox"/> Treatment medically contraindicated <input type="checkbox"/> Declined against medical advice	
Please check one of the boxes below and sign: <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 has no symptoms. <input type="checkbox"/>	
_____ Health Care Provider Signature, Title <span style="float: right;">Date</span>	

<b>Name/Title of Health Provider:</b> <b>License Number:</b> <b>Facility/Address:</b> <b>Phone number:</b>
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# County of Santa Clara

## Public Health Department



Tuberculosis Prevention & Control Program  
976 Lenzen Avenue, Suite 1700  
San José, CA 95126  
408.885.2440

### Testing Methods

An Interferon Gamma Release Assay (IGRA, i.e., QuantiFERON or T-SPOT.TB) or Mantoux tuberculin skin test (TST) should be used to test those at increased risk. An IGRA can be used in all children  $\geq 2$  years old and is preferred in BCG-vaccinated children to avoid a false positive TST result. A TST of  $\geq 10$ mm induration is considered positive. If a child has had contact with someone with active TB disease (yes to question 2 on reverse), or the child is immunosuppressed, then TST  $\geq 5$  mm is considered positive. If a BCG-vaccinated child has a positive TST, and an IGRA is subsequently performed and is negative, testing is considered negative unless the child was exposed to someone with TB disease or is immunosuppressed. For immunosuppressed children, screening should be performed by CXR in addition to a TST/IGRA (consider doing both) and symptom review. TB screening can be falsely negative within 8 weeks after exposure, so are best obtained 8 weeks after last exposure.

### Evaluation of Children with Positive TB Tests

- All children with a positive IGRA/TST result must have a medical evaluation, including a CXR (posterior-anterior and lateral is recommended for children  $< 5$  years old). A CXR is not required for a positive TST with negative IGRA in a BCG-vaccinated child, or if the child has documentation of prior treatment for TB disease or treatment for latent TB infection.
- For children with TB symptoms (e.g., cough for  $> 2-3$  weeks, shortness of breath, hemoptysis, fever, weight loss, night sweats) or an abnormal CXR consistent with active TB disease, report to the County of Santa Clara Public Health Department TB Program within one day. The child will need to be evaluated for TB disease with sputum AFB smears/cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease in a patient with symptoms or signs of TB disease. The child cannot enter school unless active TB disease has been excluded or treatment has been initiated.
- 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). Do not treat for LTBI until active TB disease has been excluded.
- Short-course regimens (rifampin daily for four months or 12-dose weekly isoniazid/rifapentine) are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid.

### Treatment Regimens for Latent TB Infection

- Rifampin 15 - 20 mg/kg (max. 600 mg) daily for 4 months
- 12-dose Weekly Isoniazid/Rifapentine (3HP) Regimen:
  - Isoniazid
    - 2-11 years old: 25 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
    - $\geq 12$  years old: 15 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
  - Rifapentine
    - 10.0-14.0 kg: 300 mg
    - 14.1-25.0 kg: 450 mg
    - 25.1-32.0 kg: 600 mg
    - 32.1-50.0 kg: 750 mg
    - $> 50$  kg: 900 mg
  - Vitamin B6 50 mg weekly
- Isoniazid 10 mg/kg (range, 10-15 mg/kg; max. 300 mg) daily for 9 months. Recommended pyridoxine dosage is 25 mg for school-aged children (or 1-2 mg/kg/day).

Board of Supervisors: Mike Wasserman, Cindy Chavez, Otto Lee, Susan Ellenberg, S. Joseph Simitian,  
County Executive: Jeffrey V. Smith



**MORGAN HILL UNIFIED SCHOOL DISTRICT**  
**MIGRANT CENTER**  
 15600 CONCORD CIRCLE, MORGAN HILL, CA 95037  
 PHONE: 408-201-6030 | EMAIL: [enrollment@mhusd.org](mailto:enrollment@mhusd.org)

If you qualify for the Migrant Program you may be eligible for:  
 \*Preschool Services \*Health Services \*Free food and transportation  
 \*Academic Resources-PASS Program-credit recovery \*Summer School Programs

Student's Name: \_\_\_\_\_ School Name: \_\_\_\_\_  
 Parent's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Today's Date: \_\_\_\_\_

1. Has your family moved in or out of the Morgan Hill area within the last 3 years?  
 (Circle) **Yes** **No**
2. When you move within the last 3 years, did you or a member of your family seek or obtain seasonal employment in one or more of the following? (Circle) **Yes** **No**

- ( ) Agriculture ( ) Food Packaging  
 ( ) Dairy ( ) Fishing Industries  
 ( ) Plant Nursery

\*\*Please fill out completely and return to your child's school.



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Si califican para el programa migrante puede ser elegible para:  
 \*Servicios pre-escolares \*Comida y transporte gratis  
 \*Servicios de salud \*Recursos académicos-Recuperación de créditos PASS \*Programa de escuela de verano

Nombre del estudiante: \_\_\_\_\_ Escuela: \_\_\_\_\_  
 Nombre de padres: \_\_\_\_\_ Teléfono: \_\_\_\_\_  
 Fecha: \_\_\_\_\_

1. ¿Se ha mudado su familia fuera o dentro de la ciudad de Morgan Hill-San Martín durante los últimos 3 años?  
 (Circule) **Sí** **No**
2. Cuando se mudaron en los últimos 3 años, ¿usted o algún miembro de su familia buscó u obtuvo trabajo temporal en uno o más de lo siguiente? (Circule) **Sí** **No**

- ( ) En el campo ( ) Empacadoras  
 ( ) Lechería ( ) Pesca  
 ( ) Viveros

\*\*Favor de llenar completamente y regresar a la escuela de su hijo (a)