MAMARONECK UNION FREE SCHOOL DISTRICT

HEALTH OFFICE

Tuberculosis Screening/Clearance

Student's Name _____

Mamaroneck Schools require TB risk assessment for all incoming new students.

Students with **NO RISK FACTORS** do not require further testing.

_____ This student has no TB risk factors

MD SIGNATURE HERE_____

DATE_____ STAMP_____

Students with Risk Factors require TB testing:

_____ History of TB exposure

_____ Immigration from high incidence countries (Asia, Africa, Eastern Europe, Central & South America)

_____ Lodging with local residents, families in high incidence countries during travel

_____ Household contact with family members from high incidence countries

_____ Exposure to HIV infected, homeless, drug using or incarcerated individuals

_____ **TUBERCULIN SKIN TEST (TST)**

Date Placed_____ Date Read_____

mm of Induration_____

_____ Chest X-ray results

MD SIGNATURE HERE _____

DATE_____ STAMP_____

Please see over for helpful information

These countries have LOW RATES OF TB. (2013)

Albania, America Samoa, Andorra, Antigua and Barbuda, Australia, Austria, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom, United States Virgin Islands, United States of America

All other countries not listed have high rates of TB exposure (and require testing)

If Tuberculin Test or IGRA is positive, now or previously, the following are required:

1. **Date of Positive TST or IGRA** **Date**: _____/ _____/ _____

2. **Chest X-ray: (Please attach copy of report)** **Date**: _____/ _____/ _____

   _____ **Normal**

   _____ **Abnormal** _____
   (Describe)

3. **Clinical Evaluation:**
   _____ **Normal**

   _____ **Abnormal** _____
   (Describe)

4. **Treatment:**
   _____ **No** _____
   (Please explain)

   _____ **Yes** _____
   (Drug, Dose, Frequency, Dates)

Additional review of history, if indicated:

- BCG Vaccine _____date
- Previous POS TST_____ date
- Previous treatment_____date

Any other comments _____

Thank you.