Board of Education
Simon Wright
Maria M. Caceres
Rachael Robles
Maria E. Cruz, DSW
Sue L. Maulucci

Examen de Tuberculosis - Prueba Cutánea de Mantoux

Cada cuatro años, según el Código de Educación, todos los voluntarios escolares deben presentar un comprobante que no padecen de tuberculosis activo. El requisito es una prueba cutánea de Mantoux, que consiste en una inyección y una visita de regreso dos días después para la lectura.

Si lo desea, puede hacerse la prueba de tuberculosis con su propio médico. Infórmele que la ley estatal requiere la prueba de Mantoux y que la prueba de la tiña no se acepta. También puede hacerse la prueba en el siguiente centro de salud por una tarifa, que puede pagarse en efectivo o con cheque:

Concentra Industrial Clinic
626-969-9800
15768 Arrow Hwy.
Irwindale, CA 91706

La clínica proporcionará la radiografía de revisión a quienes tengan un resultado positivo en la prueba de Mantoux, o puede acudir a su médico personal. El costo de cualquier radiografía de revisión debe pagarlo usted. Asegúrese de mantener una copia para sus registros.

Alternativamente, las provisiones de la Ley Asamblea (AB) 1667, que entró en vigor el 1 de enero de 2015, permite a los empleados y voluntarios no someterse a la prueba física de tuberculosis y completar un cuestionario de evaluación de riesgo de tuberculosis. Si se identifican factores de riesgo, solo se les requiere la prueba y el examen de tuberculosis para determinar que la persona no padece de tuberculosis infeccioso. La evaluación de riesgo de tuberculosis debe ser administrada/completada por un proveedor de atención medica autorizado (médico, asistente médico, enfermero practicante o enfermero registrado) y los resultados deben entregarse junto con el paquete completado.

Le recomendamos encarecidamente que complete la prueba cutánea de Mantoux o el Cuestionario de Riesgo lo antes posible.

Gracias por su cooperación para cumplir con este requisito.

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VOLUNTEER/CHAPERONE TB SCREENING HISTORY

Name (Last, First, Middle Initial)	**DOB**
Signature	**Date**

I hereby give my consent to have a Mantoux skin test. I certify that the following information is true.

Have you ever or currently have any of the following (check yes or no):	**Yes**	**No**
1. Medicine for TB or for a positive skin test (Medical documentation required)	☐	☐
2. Recent immunization for measles, mumps, or rubella in the last 30 days	☐	☐
3. BCG vaccination If yes, when?	☐	☐
4. Known exposure to someone with TB If yes, when?	☐	☐
5. Diabetes	☐	☐
6. Epilepsy	☐	☐
7. Lung problems	☐	☐
8. Treatment with cancer medicines	☐	☐
9. Steroids or cortisone	☐	☐
10. Chronic cough	☐	☐
11. Loss of appetite	☐	☐
12. Night sweats	☐	☐
13. Blood in sputum	☐	☐
14. Shortness of breath	☐	☐
15. Weight loss	☐	☐
16. Are you pregnant?	☐	☐
17. Allergies? (Please list)	☐	☐
18. Currently taking medication? (Please list)	☐	☐

Skin Test

Date Given:	Reading:	Read Date:

Chest X-Ray

☐ The patient had a chest X-ray on Date: _____and is determined to be free of infectious tuberculosis.

Healthcare Provider Signature & Stamp: _____

California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading disease.
- **Do not repeat testing** unless there are **new risk factors since the last negative test**.
- **Do not treat for latent TB infection (LTBI) until active TB disease has been excluded**:
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____ **Date of Birth:** _____

History of Tuberculosis Disease or Infection (Check appropriate box below)
☐ **Yes** • If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.
☐ **No** (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked
☐ **One or more sign(s) or symptom(s) of TB disease** • TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.
☐ **Birth, travel, or residence** in a country with an elevated TB rate for at least 1 month • Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries. • Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.
☐ **Close contact** to someone with infectious TB disease during lifetime
Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

CDPH PublicHealth

CTCA CALIFORNIA TUBERCULOSIS CONTROLLERS ASSOCIATION

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

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.

X_____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):