



**Board of Education**

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**Información sobre los requisitos de tuberculosis**

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 médica autorizado (médico, asistente médico, enfermero practicante o enfermero registrado) y los resultados deben entregarse junto con el paquete completado.

Gracias por su cooperación para cumplir con este requisito.



**VOLUNTEER/CHAPERONE TB SCREENING FORM**

<b>Name (Last, First, Middle Initial)</b>	<b>DOB</b>
<b>Signature</b>	<b>Date</b>

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

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

**Skin Test**

Date Given:	Reading:	Read Date:
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**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).



## 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):**