Student Tuberculosis Risk Assessment Questionnaire

Delaware Department of Education

Instructions

Before using this form, the school nurse must review the student's health records and confirm that the student meets the requirements for a current physical examination and up-to-date immunizations. The school nurse must administer this questionnaire to the parent or guardian in person or by telephone. The parent or guardian who answers the questions must sign the form.

Student Information

Student name _____

Date of birth: ____ / ____ / _____ **Date completed:** ____ / ____ / _____

Risk Assessment Questions

Choose Yes or No for each question.

Question	Yes	No
1. Has your child had contact with a person who has tuberculosis (TB)?		
2. Was your child or any household member born in, or has your child or any household member traveled to, an area where TB is common, such as Africa, Asia, Latin America, or the Caribbean?		
3. Does your child have regular, such as daily, contact with adults at high risk for TB, including people who are HIV-positive, experiencing homelessness, incarcerated, or using illicit drugs?		
4. Does your child have a health condition or take medication that might affect the immune system?		

Important: Any Yes response is considered a positive risk factor and indicates that the child should receive a Mantoux tuberculin skin test.

School Nurse Determination

The school nurse screened this student for risk of exposure to tuberculosis. Based on the responses above, select one determination:

The student does not require a Mantoux tuberculin skin test.

The student requires a Mantoux tuberculin skin test.

If testing is required: Mantoux testing must be completed, and documentation must be provided to the school nurse by ____ / ____ / _____. If documentation is not received by this date, the student will be excluded from school.

Comments and Signatures

School nurse comments _____

_____

School nurse signature: _____ **Date:** ____ / ____ / _____

I give permission for the school nurse and my child's primary care physician named below to share information related to this form.

Primary care physician name _____

Parent or guardian signature: _____ **Date:** ____ / ____ / _____