

Middlesex School TB Risk Assessment Form
(To be completed by medical provider)

The purpose of the TB Risk Assessment Form is to identify children who may be at increased risk for tuberculosis (TB) and may require evaluation and testing. Any risk factor described below is an indication for TB testing.

Child's Name: _____ DOB: _____ Date: _____

TB Risk Assessment	Yes	No
Was the child born in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East? If yes, in what country was the child born? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has the child lived or traveled in Africa, Asia and Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than one month?	<input type="checkbox"/>	<input type="checkbox"/>
In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	<input type="checkbox"/>	<input type="checkbox"/>
Have any members of the child's household come to the United States from another country?	<input type="checkbox"/>	<input type="checkbox"/>
Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	<input type="checkbox"/>	<input type="checkbox"/>

Test for TB

Test, using a TST or IGRA, only those Students identified to be at risk of exposure using Assessment above.
IGRA is the preferred test for Students with a history of BCG.

TB Test Documentation

If TB test is NOT required please indicate: **Low Risk** _____ **Date:** _____ (MM/DD/YY)

If TB test is required, please indicate TB Test Type and Results:

Tuberculin Skin Test Plant Date: _____ (MM/DD/YY) TST Read Date: _____ (MM/DD/YY)

TST Result: _____ (Millimeters of Induration) TST interpretation: Positive _____ Negative _____

Interferon-Gamma Release Assay (IGRA) performed on: _____ (MM/DD/YY)

IGRA Interpretation: Positive _____ Negative _____

Indeterminate/Borderline (requires repeat test) _____

Medical Provider Signature: _____ **Date:** _____

Please Print Name of Examiner _____

Group Practice _____ **Telephone** _____

Address _____

City/State/Country/ZipCode _____