CHILD AND YOUTH TUBERCULOSIS SCREENING CERTIFICATE

TO BE COMPLETED BY HEALTH CARE PROVIDER
(EL PROVEEDOR MÉDICO DEBE COMPLETAR ESTE FORMULARIO)

1. Does child/youth have any of the following symptoms?

   ____ Cough >3 weeks ____ Unexplained fever ____Night sweats ____Unexplained weight loss

   ☐ No to all → Go to question #2
   ☐ Yes to any → Evaluate symptoms

2. Has the child/youth ever had a positive (+) Tuberculosis Skin Test (TST)?

   ☐ No→ Go to question #3
   ☐ Yes→ Confirm that child/youth was appropriately evaluated, i.e., had a documented negative x-ray and treatment for latent TB infection was recommended

3. Ask all the following **risk assessment** questions and check the box if the answer is YES*

   a. ☐ *Was the child born in a high risk country?** (If yes, plant only if no prior TST)*

   Since the child/youth's last Risk Assessment or last negative TST:

   b. ☐ *Has the child/youth traveled in (≥1 week) a high-risk country?** (If yes, plant TST at least 10 weeks after return from travel.)* ***TST will be due*______________________
   c. ☐ *Has the child/youth lived in (≥3 months) a high risk country?***
   d. ☐ *Has a household member or close contact of the child/youth had tuberculosis disease?*
   e. ☐ *Has a household member or close contact of the child/youth had a positive TST?*
   f. ☐ *Has the child/youth been a resident of a shelter, prison, or jail?*
   g. ☐ *Has a close contact of the child/youth been a resident or employee of a shelter, prison, jail, nursing home or assisted living facility?*

   CONTINUE ONLY IF CLIENT IS < 6 YEARS OF AGE:

   h. ☐ *Was a parent or guardian of the child born in a high risk country?** (If yes, plant only if no prior TST)*
   i. ☐ *Has the child had household or close contact with people (e.g., a babysitter) from a high risk Country?***

   ***If yes to any of questions 3a – i, plant TST and read at 48-72 hours**
   **High risk countries = Countries other than the US, Canada, Australia, New Zealand, or in Western Europe

If desired, clip along dotted line and give portion below to parent for child's school.

CERTIFICATE OF TB SCREENING

Name of child/youth:______________________________________**DOB** ___________**School**________________________

____ Risk factor identified, TST placed on _____________ TST results______mm Date TST read ______________

____ Prior documented (+) TST, no TST planted

____ No risk factors identified, no TST needed

___________________________________ Date_________
Physician's or RN's signature

Physician's stamp & address here: