HEALTH EXAMINATION
FOR CHILD CARE FACILITY PERSONNEL

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Facility's Name

On ___________________________ **I have examined** __________________________________
Date ***Name***

and found him or her physically qualified to care for children.

TB RISK ASSESSMENT COMPLETED **Yes** **No**

Signature/Title of Health Care Provider	***Date***	***Address (Please print or stamp)***
	___/____/____	
Name (Please print or stamp)		

<u>Tuberculosis Targeted Testing Guidelines</u>

Tuberculosis Infection Risk:
Review the following risks and administer a Tb Skin Test if this person is in one or more of the Following categories.

- Recent immigrant (< 5 years) or Frequent visitor to TB endemic area
- Close contact to active TB case
- Frequent contact with others at high risk for the disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+, or has other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss>10% of ideal body weight, on immunosuppressive medications.

Active TB Disease Risk:

- Does the person exhibit signs/symptoms of Tuberculosis (e.g. cough for three (3) weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.

NOTE: This form must be completed fully and signed and dated.

PLEASE RETURN ONLY THIS PAGE TO CLIENT.

CONFIDENTIAL INFORMATION

Physician: Please keep this page for client’s medical records

Patient’s Name____________________________ Date: ______________

<u>TB RISK ASSESSMENT</u>

The following questions are to be answered by patients with coughing symptoms:

1. How long have you been coughing? Number of weeks _______________

(Check the appropriate answer)

2. Have you been coughing up blood?	**Yes**	**No**
3. Have you had unexplained weight loss or decrease in appetite during the past two (2) months?	**Yes**	**No**
4. Do you experience night sweats?	**Yes**	**No**
5. Have you had persistent low-grade fever?	**Yes**	**No**
6. Have you lived or worked with anyone with any of these symptoms?	**Yes**	**No**
7. Have you ever had a positive skin test for TB? If yes, when ____________________	**Yes**	**No**
8. Have you lived or worked with anyone who was sick with TB within the last two (2) years?	**Yes**	**No**
9. Have you ever been treated for active TB in the past? If yes, when____________________	**Yes**	**No**
10. Do you have any condition that may weaken your immune system (i.e. cancer, HIV, rheumatoid arthritis, emphysema, diabetes, alcoholism, silicosis)?	**Yes**	**No**
11. Do you take cortisone?	**Yes**	**No**
12. Have you had stomach surgery?	**Yes**	**No**

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Signature of Interviewer Date