

CHILD AND YOUTH TUBERCULOSIS SCREENING CERTIFICATE

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

NAME _____

DATE _____

1. Does child/youth have any of the following symptoms? (Check all that apply.)

____ 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 YES or NO.

a. YES NO Was the child/youth 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. YES NO 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. YES NO Has the child/youth lived in (≥ 3 months) a high risk country?*

d. YES NO Has a household member or close contact of the child/youth had tuberculosis disease?

e. YES NO Has a household member or close contact of the child/youth had a positive TST?

f. YES NO Has the child/youth been a resident of a shelter, prison, or jail?

g. YES NO 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. YES NO Was a parent/guardian of the child born in a high risk country?* (If yes, plant only if no prior TST)

i. YES NO Has the child had household or close contact with people (e.g., a babysitter) from a high risk country?*

If NO to 3a-i, sign certificate below.

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

CDC Classification of Positive TST Reaction

≥ 5 mm: HIV+ persons, recent contacts of TB case, patients with organ transplant, other immunosuppressed patients

≥ 10 mm: children 4 years or younger or anyone else with positive response to the risk questions above.

Tuberculin Skin Test (TST)

Date planted: _____ Site: LFA / RFA

Planted by: _____

Date read: _____ Induration _____ mm

Read by: _____

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 or RN signature

Physician's stamp & address here:



PUBLIC HEALTH DIVISION

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Prevent. Promote. Protect.