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)*

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

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

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

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

   f. ☐ 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:

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

   h. ☐ 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 = See https://www.cdc.gov/tb/publications/ltbi/appendixb.htm

CDC Classification of Positive TST Reaction
≥ 5mm: HIV+ persons, recent contacts of TB case, patients with organ transplant, other immunosuppressed patients

≥ 10mm: 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:

ARLINGTON VIRGINIA
PUBLIC HEALTH DIVISION

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Public Health
Prevent. Promote. Protect.