

DELAWARE DEPARTMENT OF EDUCATION

Tuberculosis (TB) Risk Assessment Questionnaire for Students¹

Prior to use of this form, the school nurse must review the student's health record and assure that the student is compliant with the requirements for a current health examination (within past 2 years) and up-to-date immunizations. The questionnaire must be administered by the school nurse to the parent/guardian in person, or by phone, and signed by the person who answered the questions.

Name: _____
Last First MI

Date of Birth: ____/____/____ Date Form Completed ____/____/____

1. Has your child had close contact² with anyone with an active infectious TB disease?
2. Was any household member, including your child, born in or has he/she traveled to area(s) where TB is common? (Refer to the Tuberculosis High Burden Countries list provided by the Delaware Division of Public Health.)
3. Does your child have regular (i.e., daily) contact with adults at high risk for TB (i.e., those who are HIV infected, homeless³, incarcerated⁴, and/or illicit drug users)?
4. Does your child have a history of HIV infection, living in a shelter, incarceration, or illicit drug use?
5. Does your child have any health conditions or take medications that might affect his/her immune system?
6. Has your child ever had a positive test for tuberculosis?

Any "yes" response to questions 1 - 5 is considered a positive risk factor and is an indication for administering a Mantoux tuberculin skin test or a TB blood test, such as The Quantiferon Gold TB Test, to the child.

A "yes" response to question 1 -6 indicates probable previous exposure to TB, and requires medical follow-up to evaluate medical status.

This child has been screened by his/her school nurse for risk of exposure to tuberculosis. Based upon the results of the TB Risk Assessment Questionnaire the child,

- Does not** require a Tuberculosis Test **Does** require documentation related to current disease status
- Does** require a Tuberculosis Test

TB testing and documentation must be completed and given to the school nurse by ____/____/____ (date) or your child will be excluded from school.

School Nurse Comments: _____

School Nurse (signature) _____

Parent/Guardian (signature) _____

I give permission for the school nurse and my child's primary care physician _____
(name of physician) to share information relating to this form.

Name _____ Date _____
Parent/Guardian (signature) _____

¹TB assessment is required by Regulation 805, <http://regulations.delaware.gov/AdminCode/title14/800/805>. The questionnaire was developed by Delaware Department of Education and the Division of Public Health. Revised 7/1/13, 5/2015, 4/2018.

²CDC describes "close contact" as prolonged, frequent, or intense contact with a person with TB, while he/she was in infectious.

³The term "homeless" means a situation where the person lived in a shelter or with others.

⁴Incarceration should be longer than one week.