Tuberculosis Screening Form

10A NCAC 09 .0701 (a) (Centers)

This questionnaire must be administered to all child care providers, by a licensed health care professional, before coming into contact with children. Directors, substitutes, and individuals who volunteer more than once a week must be screened. Testing should only be performed if the individual answers "yes" to one of the screening questions. Both screening and testing are available at the local health department.

Note to health care professionals: A negative risk and symptom screen should be considered a negative tuberculosis test in such individuals, and no further testing is required. An Interferon Gamma Release Assay is preferred over a tuberculin skin test for otherwise low-risk individuals with a positive response to the risk or symptom screening questionnaires. (See page 2.)

Last name (print clearly)	First name	Middle	Date of Birth

Tuberculosis Risk Questionnaire

1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	**YES**	**NO**
2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?	**YES**	**NO**
3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis?	**YES**	**NO**
4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients?	**YES**	**NO**
5) Have you ever been exposed to anyone with infectious tuberculosis?	**YES**	**NO**

Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?		
1) Unexplained cough lasting more than 3 weeks?	**YES**	**NO**
2) Unexplained fever lasting more than 3 weeks?	**YES**	**NO**
3) Night sweats (sweating that leaves the bedclothes and sheets wet)?	**YES**	**NO**
4) Shortness of breath?	**YES**	**NO**
5) Chest pain?	**YES**	**NO**
6) Unintentional weight loss?	**YES**	**NO**
7) Unexplained fatigue (very tired for no reason)?	**YES**	**NO**

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.

Signature:	Date:

Screening administered by licensed health care professional:

Printed name and location:	
Signature:	Date:

Tuberculosis Testing Form

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Record of Tuberculosis Test

Last name (print clearly)	First name	Middle	Date of birth

Type of test:

☐ Tuberculin

Date given	
Date read	
Results	MM reading: _____ ☐ Negative ☐ Positive

☐ Interferon Gamma Release Assay

Date	
Results	

Comments:

Signature of Authorized Health Professional	Date	Location

NC Child Care Health and Safety Resource Center