School Staff & Volunteers: Tuberculosis Risk Assessment

Job-related requirement for childcare, pre-K, K-12, and community colleges

The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading TB. Use of this risk assessment is required in the California Education Code, Sections 49406 and 87408.6 and the Health and Safety Code, Sections 1597.055 and 121525-121555.

The law requires that a health care provider administer this risk assessment. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. Any person administering this risk assessment is to have training in the purpose and significance of the risk assessment and Certificate of Completion.

Name of Employee/Volunteer Assessed for TB Risk Factors: _____

Assessment Date: _____ **Date of Birth:** _____

History of Tuberculosis Infection or Disease (Check appropriate box below)

☐ **Yes**

If there is a documented history of positive TB test (infection) or TB disease, then a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. Once a person has a documented positive test for TB infection that has been followed by an x-ray that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required. If an employee or volunteer becomes symptomatic for TB, then he/she should seek care from his/her health care provider.

☐ **No** (Assess for Risk Factors for Tuberculosis using box below)

Risk Factors for Tuberculosis (Check appropriate boxes below)

If any of the 5 boxes below are checked, perform a Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA). A positive TST or IGRA should be followed by a chest x-ray, and if normal, treatment for TB infection considered. (Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013)

☐ **One or more signs and symptoms of TB:** prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue.

Evaluate for active TB disease with a TST or IGRA, chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease.

☐ **Close contact** to someone with infectious TB disease at any time

☐ **Foreign-born** person from a country with an elevated TB rate

Includes countries other than the United States, Canada, Australia, New Zealand, or a country in Western and Northern Europe. IGRA is preferred over TST for foreign-born persons

☐ **Consecutive travel or residence of ≥ 1 month** in a country with an elevated TB rate

Includes countries other than the United States, Canada, Australia, New Zealand, or a country in Western and Northern Europe.

☐ Volunteered, worked or lived in a **correctional or homeless** facility

Re-testing with TST or IGRA should only be done in persons who previously tested negative, and have new risk factors since the last assessment.

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

To satisfy job-related requirements in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X_____
Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name, Address (include Number, Street, City, State, and Zip Code):

Telephone/FAX: