

Tuberculosis Screening Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

This questionnaire must be administered to all child care providers, by a licensed health care professional, before coming into contact with children. Directors, operators, additional caregivers, 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:
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Screening administered by licensed health care professional:

Printed name and location:	
Signature:	Date:

*This information must be included in the operator or staff member’s medical file, which must be maintained separately from the operator or staff member’s individual personnel file that is kept on site.



Tuberculosis Testing Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

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: _____ <input type="checkbox"/> Negative <input type="checkbox"/> Positive

Interferon Gamma Release Assay

Date	
Results	

Comments:

Signature of Authorized Health Professional	Date	Location

*This information must be included in the operator or staff member’s medical file, which must be maintained separately from the operator or staff member’s individual personnel file that is kept on site.

