

TB Risk Assessment Questionnaire

Child's Name: _____ DOB: _____

Center/Home Based Site: _____

Family Worker/Home Visitor: _____

Date: _____

Person interviewed: _____

TB Risk Assessment Questionnaire

1. Was your child born outside the United States? YES NO

If yes, where? _____

2. Has your child traveled outside the United States? YES NO

If yes, where? _____ When? _____

Who did your child stay with? _____

How long did your child travel? _____

3. Has your child been exposed to anyone with TB disease? YES NO

If yes, when was the exposure? _____

4. Does your child have close contact with a person who has a positive skin test?
YES NO

If yes, when was the exposure? _____

Scan completed Questionnaire to Health

To be completed by SHS Registered Nurse:

Referred to Health Care Provider YES NO

Date: _____

Signed: _____