



PEDIATRIC TB RISK ASSESSMENT FORM

Physician/ Health Provider: _____	Phone: _____	Date: _____
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Child's Name: _____ **Date of Birth:** ____ / ____ / ____

Address: _____ **City:** _____ **State:** _____ **County:** _____

Sex: Male Female **Hispanic:** No Yes **Race:** White Black Asian Am. Indian/Nat. Alaskan Other _____

US Born: Yes No **If no, US Date of Arrival:** ____ / ____ / ____ **Country of Birth:** _____

Parent/Guardian: _____ **Phone:** _____

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of symptoms: _____
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what country was the child born: _____
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, in what country did the child travel to: _____
5. Have any members of the child's household come to the United States from another country?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of country: _____
6. Is the child exposed to a person who: <ul style="list-style-type: none"> • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker? 	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name the risk factors the child is exposed to: _____ _____
7. Is the child/teen in jail or ever been in jail?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of jail: _____
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of disease or medications: _____

If yes, to any of the above, the child has an increased risk of TB infection and should have a TST/IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. If testing was done, please attach or enter results on next page.