REPORT OF TUBERCULOSIS SCREENING
CHILDREN'S PROGRAMS

Standards and child care policy require certain individuals to submit a report indicating the absence of tuberculosis in a communicable form when involved with (i) children's facilities regulated by the Department of Social Services or (ii) legally operating child care programs, excluding care by relatives, that receive Child Care and Development Funds. Each report must be dated and signed by the examining physician, the physician's designee, or an official of a local health department. When signed by the physician's designee, the form must also identify the physician/physician practice with which the physician –designated screener is affiliated.

Name: _____ **Date of Birth**: _____

Address (Street, City, State, Zip Code): _____
_____

1). ____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

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2). Tuberculin Skin Test (PPD): Date given: _____ Date read: _____

Results: _____ mm Positive: _____ Negative: _____

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3). ____ The individual has a history of a positive tuberculin skin test (latent infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

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4). ____ The individual either is currently receiving or has completed medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

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5). ____ The individual had a chest x-ray on _____ (date) at _____ (location) that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature/Title: _____ Date: _____
(MD/designee or Health Department Official)

_____
(Print Name/Title)

Address (including name of practice, if appropriate):
_____
_____
_____
_____

Telephone number: _____