**TB QUESTIONNAIRE: STUDENTS**
**Catholic Schools Office**
Archdiocese of Galveston-Houston

Name of Child:_____ Date of Birth: _____

School: _____ Date: _____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child. Children who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats. A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI). Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB. We need your help to find out if your child has been exposed to tuberculosis.

All information obtained herein will be kept in confidence

| Place a mark in the appropriate box: | Yes | No | Don't Know |
|---|---|---|---|
| TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know:<br>• Has your child been around anyone with any of these symptoms or problems? or<br>• Has your child had any of these symptoms or problems? or<br>• Has your child been around anyone sick with TB? | | | |
| Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia? | | | |
| Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks?<br>If so, specify which country/countries? _____ | | | |
| To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country? | | | |

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___
Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

_____
Parent signature Date

**********

**For Physician use only-** (Must be a practicing physician/provider in the state of Texas per Texas Department of State Health Services guidelines)

PPD administered No___ Yes___ If YES:

Date administered: _____/_____/_____ Date read: _____/_____/_____ Result of PPD test: _____ mm response

_____
PPD provider signature printed name

City: _____ County: _____

Type of service provider (i.e. school, Health Steps, other clinics)_____

If positive, referral to physician No____ Yes____ If yes, name of provider: _____