NORRISTOWN AREA SCHOOL DISTRICT

TUBERCULOSIS SCREENING

_____ **Date of Birth** ___/___/____ **Age**_____
Last Name *First Name* *Middle Initial*

Country of Birth:_____ **When did you come to the US?**
Month_____ **Year**_____

Traveled outside US? ☐ **Yes** ☐ **No** **If Yes: Where?** _____ **When?** _____

How Long?_____

Please answer the following questions regarding your child

Check one – Yes or No

1. Has your child had a previous skin test for Tuberculosis? ☐ Yes ☐ No

   If Yes: Date ___/___/_____ Result: _____

2. Has your child taken medicine for Tuberculosis or for a positive skin test? ☐ Yes ☐ No

   If Yes: Date ___/___/_____

3. Has your child had a known exposure to someone with Tuberculosis? ☐ Yes ☐ No

4. Has your child had a blood test for the AIDS virus? ☐ Yes ☐ No

   If Yes: Date Given ___/___/_____ Result:_____

5. Has anyone associated with the child spent time living in prison, a residential facility or a homeless shelter? ☐ Yes ☐ No

   If Yes: Date ___/___/_____

Reviewed by Registrar:_____ Date:_____