



# Upper Merion Area School District

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## SCHOOL HEALTH SERVICES

### TUBERCULOSIS SCREENING ASSESSMENT

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_

Parent/Guardian \_\_\_\_\_

HAS CHILD OR ANY FAMILY MEMBER..... YES NO

1. Been in contact with someone known or suspected of having tuberculosis?  YES  NO
2. Been exposed to someone with an undiagnosed chronic (prolonged) cough?  YES  NO
3. Traveled to Asia, Middle East, Latin America or Africa or been in contact with someone who has?  YES  NO
4. Been exposed to someone who is HIV infected?  YES  NO
5. Been exposed to someone who has been in jail or an institution such as a hospital, nursing home, group home, etc.?  YES  NO
6. Do you know of any tuberculosis cases that have been discovered in your neighborhood?  YES  NO
7. Have you moved here from a developing country or been in contact with someone who has?  YES  NO

Parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

For nursing staff use:

Medical evaluation required  Yes  No

If yes, referred to \_\_\_\_\_  
Evaluation/Testing to be completed by \_\_\_\_\_

School Nurse \_\_\_\_\_ Date \_\_\_\_\_

Health Room Assistant \_\_\_\_\_ Date \_\_\_\_\_

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