



Central Council Tlingit and Haida Indian Tribes of Alaska

TLINGIT & HAIDA HEAD START

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Tuberculosis Risk Assessment Form

Date: _____

Parent/Guardian: _____

Please complete this TB risk assessment regarding your Head Start student

CHILD'S NAME:	DATE OF BIRTH:
HEAD START CENTER:	
TB TESTING IS REQUIRED IF ANY "YES" BOXES ARE CHECKED	
Close contact to someone with infectious TB during the student's lifetime <ul style="list-style-type: none"> Re-testing should only be done in children who previously tested negative and have had no closecontact with an infectious TB case since the last assessment. 	<input type="checkbox"/> Yes
Birth, travel or residence in a country with an elevated TB rate for at least 1 month <ul style="list-style-type: none"> Includes any country other than the United States, Canada, Australia, New Zealand, or a countryin western or northern Europe 	<input type="checkbox"/> Yes
Immunosuppression , current or planned <ul style="list-style-type: none"> HIV infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids for morethan 2 weeks (i.e., equivalent of prednisone ≥ 2 mg/kg/day, or ≥ 15mg/day for ≥ 2 weeks), or other immunosuppressive medication. 	<input type="checkbox"/> Yes
IF NONE OF THE ABOVE APPLY, TB TESTING IS NOT REQUIRED AT THIS TIME.	
Please note: <ul style="list-style-type: none"> Do not repeat TB <u>testing</u> unless there are <i>new</i> risk factors since the last negative test. Children with a newly positive TB test result will be referred to their healthcare provider for a medical evaluationand parents/guardians will be notified. 	
PARENT/GUARDIAN SIGNATURE:	DATE: