

**Solano County Office of Education**  
**Adult Tuberculosis (TB) Risk Assessment Questionnaire**

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)  
*To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)*

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Risk Assessment: \_\_\_\_\_

History of positive TB test or TB disease      Yes ☐      No ☐

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire. \*  
If no, continue with questions below.

If there is a "Yes" response to any of the questions 1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB. <sup>1</sup>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Close contact with someone with infectious TB disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Birth in high TB-prevalence country** (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Travel to high TB-prevalence country** for more than 1 month (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes <input type="checkbox"/> No <input type="checkbox"/>

I attest that the above information is true and correct to the best of my knowledge: \_\_\_\_\_

Patient's Signature

*\*Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.*

Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

<sup>1</sup>Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013.

(<http://www.cdc.gov/tb/publications/LTBI/default.htm>)

Effective January 1, 2015

**Solano County Office of Education**

**ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE**

**CERTIFICATE OF COMPLETION**

**(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)**

**To be signed by the licensed health care provider completing the risk assessment and/or examination**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Date of Risk Assessment:** \_\_\_\_\_

*The above-named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.*

\_\_\_\_\_  
**Health Care Provider Signature**

\_\_\_\_\_  
**Please Print Health Care Provider Name**

\_\_\_\_\_  
**Office Address:**                      **Street**                                      **City**                                      **State**                                      **Zip Code**

\_\_\_\_\_  
**Telephone**                                      **Fax**