Student Name: _____ Student ID: _____

School/SY: _____ Grade: _____ Date: _____

Tuberculosis Symptom Assessment

_____ Cough for more than three weeks

_____ Unexplained fever

_____ Coughs up blood

_____ Unexplained weight loss

_____ Unexplained chest pain

_____ Night sweats

_____ Poor appetite

_____ Fatigue

For Children Under Six Years Old

_____ Wheezing

_____ Failure to thrive

_____ Decreased activity, playfulness, and/or energy

_____ Lymph node swelling

_____ Personality changes

Parent/Guardian: Please initial below:

_____ The student has not had contact with any individual known or suspected of having Tuberculosis (TB)

_____ Since the last negative TB test conducted on _____ , the student has not Resided in or traveled to a country where TB is prevalent.

Parent/Guardian Signature: _____ Date: _____

School Nurse Signature: _____ Date: _____

If student presents with one or more of the above symptoms, refer to their health care provider for further evaluations prior to school entry.