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LAGRANGE PEDIATRICS
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Child's Name _____ Date:_____

Division of Public Health
Prevention Services Branch
Tuberculosis Program
(404) 657-2634
http://health.state.ga.us/programs/tb

Tuberculosis (TB) Risk Assessment

Circle Yes or No.

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest x-ray? Yes No
2. Has the child been in close contact to a person sick with active TB disease? Yes No
3. Was the child born outside the United States or has the child traveled outside the United States? Yes No
4. Does the child have a household member who was born outside the United States or has traveled outside the United States? Yes No
5. Is the child exposed to a person who Yes No
   - Is currently in jail or who has been in jail in the past 5 years?
   - Has HIV?
   - Is homeless?
   - Lives in a group home?
   - Uses illegal drugs?
   - Is a migrant farm worker?
6. Does the child have HIV, at risk to have HIV or any other health problem that lowers the immune system? Yes No
7. Is the child / teen in jail or ever been in jail? Yes No