COVINA-VALLEY UNIFIED SCHOOL DISTRICT
TB SCREENING HISTORY

VOLUNTEER/CHAPERONE

I hereby give my consent to have a Mantoux skin test from the nurse. I certify that the following information is true.

NAME (**Please Print**) SIGNATURE DATE

HAVE YOU EVER HAD:

1.	Medicine for TB or for a positive skin test (Documentation is required from Health Dept. or Physician).	___yes	___no
2.	Recent immunization for measles, mumps or rubella in the last 30 days	___yes	___no
3.	BCG vaccination If yes, when? _____	___yes	___no
4.	Known exposure to someone with TB If yes, when? _____	___yes	___no
5.	Diabetes	___yes	___no
6.	Epilepsy	___yes	___no
7.	Lung problems	___yes	___no
8.	Treatment with cancer medicines	___yes	___no
9.	Steroids or cortisone	___yes	___no

DO YOU NOW HAVE:

10.	Chronic cough	___yes	___no
11.	Loss of appetite	___yes	___no
12.	Night sweats	___yes	___no
13.	Blood in sputum	___yes	___no
14.	Shortness of breath	___yes	___no
15.	Weight loss	___yes	___no
16.	Are you pregnant?	___yes	___no
17.	Do you take any medicines now? If yes, please list: _____ _____	___yes	___no
18.	Allergies If yes, please list. _____	___yes	___no

Skin Test

Date Given: _____Reading: _____mm. Read Date: _____

Chest X-Ray

☐ The patient had a chest X-Ray on Date: _____and is determined to be free of infectious tuberculosis.

Signature of Nurse _____