Child's Name:____ D.O.B.______________________

The following questions are to be answered by the parents/guardians of CHDP eligible patients at **EACH** periodic health assessment.

1. Do you have a family member or contact with a history of confirmed or suspected TB?

   ( ) Yes ( ) No Date:______________________

2. Are you from any foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America.)

   ( ) Yes ( ) No Date:______________________

3. Do you live in out-of-home placements?

   ( ) Yes ( ) No Date:______________________

4. Have you, or are suspected to have, HIV infection?

   ( ) Yes ( ) No Date:______________________

5. Do you live with an adult with HIV seropositivity?

   ( ) Yes ( ) No Date:______________________

6. Do you live with an adult who has been incarcerated in the last five years?

   ( ) Yes ( ) No Date:______________________

7. Do you live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes?

   ( ) Yes ( ) No Date:______________________

8. Do you have any abnormalities on chest X-ray suggestive of TB.

   ( ) Yes ( ) No Date:______________________

9. Do you have clinical evidence of TB?

   ( ) Yes ( ) No Date:______________________

DATE: PARENT/GUARDIAN SIGNATURE:

_____________________________ ______________________________________

Repeat Evaluation	Status Changed	Status Not Changed	
_______________	( )	( )	______________________
_______________	( )	( )	______________________
_______________	( )	( )	______________________
_______________	( )	( )	______________________

Comments: ____

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