Volunteer Health / Tuberculosis Assessment

This should be completed by any person(s) volunteering in a Head Start classroom regularly. (Example: One time a week or more)
(This is only a risk assessment tool and only a health care professional can determine if a medical condition exists that needs attention)**.**

1. Are you aware of any medical condition that would prevent you from volunteering in a classroom or facility? Yes No

2. Have you experienced any of the following symptoms in the past 6 months?

Coughing up blood	Yes	No
Chest Pain	Yes	No
Prolonged, cough longer than three weeks.	Yes	No
Unexplained night sweats or chills	Yes	No
Unexplained weight loss / fatigue or loss of appetite	Yes	No

3. Were you born in a high – risk country? (Countries other than the United States, Canada, Australia, New Zealand, or Western Countries) Yes No

4. Have you ever been diagnosed with tuberculosis? Yes No

5. Have you ever had a positive TB skin test or x-ray? Yes No

Note: If any questions are answered yes, follow up must be obtained.

The area below is to be completed by the doctor, health department or facility doing the follow up:

Name of person doing follow up _____ Date_____

Plan of Action if any: _____

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_____

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Revised 08/08