



**MEMORANDUM**

To: **VOLUNTEER**

Subject: Tuberculosis (PPD) Risk Assessment

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In accordance with California Education Code Section 49406, and Health and Safety Code Sections 121525-121555, the Conejo Valley Unified School District requires that persons be examined to determine if he/she is free of active Tuberculosis, no more than sixty (60) days prior to volunteering. The examination consists of a TB Risk Assessment Questionnaire certified by a health care provider, and if necessary, an intradermal Mantoux Tuberculin Skin Test (TST), which if positive (10mm or more), must be followed by a chest X-ray. If you had a positive reaction to a prior skin test, proceed with a chest X-ray.

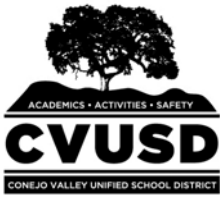
In the case of pregnancy and an intradermal TST that is positive, an X-ray examination may be delayed until after delivery, upon request of the volunteer's physician. In the interim, the physician must certify that the volunteer shows no symptoms of Tuberculosis and to the best of his/her professional judgment, presents no health hazard to students.

The Tuberculosis Risk Assessment can be obtained at **your cost** by presenting the attached form to the medical office of your choice or to any local urgent care facility. Your own physician or any other health agency may provide proof of a current Tuberculosis clearance.

It will be your responsibility to *return* the Tuberculosis (PPD) Risk Assessment, once it is completed, **to the school office where you plan to volunteer.** This assessment is good for four years, so you may want to make a copy for yourself.

**THE TUBERCULOSIS RISK ASSESSMENT MUST BE COMPLETED BEFORE VOLUNTEERING.**

**FAILURE TO COMPLY WILL RESULT IN THE SCHOOL DISTRICT NOT BEING ABLE TO ACCEPT YOUR OFFER OF VOLUNTEER SERVICES.**



**CONEJO VALLEY UNIFIED SCHOOL DISTRICT  
HUMAN RESOURCES DIVISION**

1400 E. Janss Road, Thousand Oaks, California 91362  
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\_\_\_\_\_  
**Student's Last Name First Name Grade**

**ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE**

This form is mandatory to satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555. Must be reviewed by a *licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)* prior to issuance of TB Clearance Certificate.

**Volunteer Legal Name** \_\_\_\_\_  
LAST FIRST MIDDLE

**Social Security #** XXX-XX-\_\_\_\_ Date of Birth \_\_\_\_\_

**Employment Type:**  Classified  Certificated  Volunteer

**HISTORY OF POSITIVE TB TEST OR TB DISEASE:** YES  NO

If yes, you need to submit to a symptom review and a chest x-ray (if none performed in previous 6 months) should be performed at initial hire.\*

If no, respond to the risk factor questions 1—5.

**RISK FACTOR QUESTIONS YES / NO**

1. **One or more signs and symptoms of TB** (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue). Yes  No

Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.

2. **Close contact with someone with infectious TB disease** Yes  No

3. **Birth in high TB prevalence country** (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.) Yes  No

4. **Travel to high TB prevalence country for more than 1 month** (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.) Yes  No

5. **Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter** Yes  No

⇒ If there is a "Yes" response to any of the questions 1-5 above, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

⇒ \*Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.

I hereby submit this TB Risk Assessment Questionnaire for review on \_\_\_\_\_ (date), and certify that my responses are truthful to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**AUTHORIZED HEALTH CARE PROVIDER CERTIFICATION**

DOES NOT HAVE TB RISK FACTORS

REFERRED FOR TB SKIN TEST TB test administered on \_\_\_\_\_  Negative  Positive

REFERRED FOR CHEST X-RAY / FOLLOW-UP EXAM

Health Care Provider Name \_\_\_\_\_ License No \_\_\_\_\_

Health Care Provider Signature \_\_\_\_\_ Date \_\_\_\_\_