Annual Symptomatic TB Screening Questionnaire

eKidzCare
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Notice:

In order to comply with the Department of Health's state regulations, **all staff members must complete the <u>Symptomatic TB Screening Questionnaire</u> annually.** The results are to be recorded and filed in the staff member's confidential personnel file.

Additionally, we respect the confidentiality of our staff members' health information. If there is any reason that you prefer not to complete this questionnaire, please inform your supervisor that you would prefer to be evaluated by your personal physician.

*** If you develop symptoms of Tuberculosis you should see a doctor right away and notify the eKidzCare office immediately. ***

To be completed by the employee:

1. Has anyone living with you had TB? Yes No

2. Have you ever had a positive TB Skin Test? Yes No
   If yes, please explain: ______________________________

3. Have you or anyone living with you taken medication for TB? Yes No
   [Isoniazid (INH)]

4. Is your general health different this year from last year? Yes No

5. Have you experienced any of the following recently?
   a. Persistent low grade fever Yes No
   b. Weight loss without dieting Yes No
   c. Night sweats Yes No
   d. Cough lasting 3 weeks or longer Yes No
   e. Coughing up blood Yes No
   f. Shortness of breath Yes No
   g. Chest pain worsening with respiration Yes No

   If yes, please explain: ______________________________
   ____
   ____

6. Do you have any reason to believe you have been exposed to Tuberculosis in the previous 12-months? Yes No

7. Would you like to be further evaluated by a health care professional? Yes No

Employee Signature: ______________________________ **Date:** ____________

eKidzCare Admin. Signature: ______________________________ **Date:** ____________

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