Child's Name:		Birthdate: First month/day/year			wale/Female	School:		
Address	Last,	FIISL		monuruay/year	Phone:		_ Grade:	
	Street	C	City	Zip				

Santa Clara County Public Health Department Tuberculosis (TB) Risk Assessment for School Entry

This form must be completed by a licensed health professional in the U.S. and returned to the child's school.

 Was your child born in, resided, or traveled (for more than one month) to a country with an elevated rate of TB*? 	🗆 Yes	🗆 No
2. Has your child been in close contact to anyone with TB disease in their lifetime?	Yes	🗆 No
3. Is your child immunosuppressed; current, or planned? (e.g., due to HIV infection, organ transplant, treatment with TNF-alpha antagonist or high-dose systemic steroids (e.g., prednisone \geq 15 mg/day for \geq 2 weeks).	Yes	🗆 No

*Most countries other than the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe. This does not include tourist travel for <1 month (i.e., travel that does not involve visiting family or friends, or involve significant contact with the local population).

If YES, to any of the above questions, the child has an increased risk of TB and should have a TB blood test or a tuberculin skin test (TST) unless there is either 1) a documented prior positive IGRA or TST or 2) no new risk factors since last documented negative IGRA (performed at age \geq 2 years in US or TST performed at age \geq 6 months in U.S.)

All children with a current or prior positive IGRA/TST result must have a medical evaluation, including a chest x-ray (CXR; posterior-anterior and lateral for children <5 years old is recommended). CXR is not required for children with documented prior treatment for TB disease, documented prior treatment for latent TB infection, or BCG-vaccinated children who have a positive TST and negative IGRA. If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI) to prevent progression to TB disease.

Enter test results for all children with a positive risk assessment:

Phone number:

Date of (IGRA)	Result: Negative Positive Indeterminate				
Tuberculin Skin Test (TST/Mantoux/PPD)	Indurationmm				
Date placed: Date read:	Result: D Negative D Positive				
Chest X-Ray Date: _ Impression:	Normal Abnormal				
LTBI Treatment Start Date: Rifampin daily - 4 months Isoniazid/Rifapentine - weekly X 12 Isoniazid daily - 9 months Isoniazid and Rifampin daily - 3	 Prior TB/LTBI treatment (Rx & duration): weeks Treatment medically contraindicated Declined against medical 				
advice months Please check one of the boxes below and sign: Child has no TB symptoms, no risk factors for TB, and does not require a TB test. Child has a risk factor, has been evaluated for TB and is free of active TB disease. Child has no new risk factors since last negative IGRA/TST and has no symptoms. Child has no TB symptoms. Appointment for IGRA/TST scheduled on:					
	Health Care Provider Signature, Title Date				
Name/Title of Health Provider: Facility/Address:					

County of Santa Clara

Public Health Department

Tuberculosis Prevention & Control Program 976 Lenzen Avenue, Suite 1700 San José, CA 95126 408.885.2440



Testing Methods

An Interferon Gamma Release Assay (IGRA, i.e., QuantiFERON or T-SPOT.TB) or Mantoux tuberculin skin test (TST) should be used to test those at increased risk. An IGRA can be used in all children \geq 2 years old and is preferred in BCG-vaccinated children to avoid a false positive TST result. A TST of \geq 10mm induration is considered positive. If a child has had contact with someone with active TB disease (yes to question 2 on reverse), or the child is immunosuppressed, then TST \geq 5 mm is considered positive. If a BCG-vaccinated child has a positive TST, and an IGRA is subsequently performed and is negative, testing is considered negative unless the child was exposed to someone with TB disease or is immunosuppressed. For immunosuppressed children, screening should be performed by CXR in addition to a TST/IGRA (consider doing both) and symptom review. TB screening can be falsely negative within 8 weeks after exposure, so are best obtained 8 weeks after last exposure.

Evaluation of Children with Positive TB Tests

- All children with a positive IGRA/TST result must have a medical evaluation, including a CXR (posterior-anterior and lateral is recommended for children <5 years old). A CXR is not required for a positive TST with negative IGRA in a BCG-vaccinated child, or if the child has documentation of prior treatment for TB disease or treatment for latent TB infection.
- For children with TB symptoms (e.g., cough for >2-3 weeks, shortness of breath, hemoptysis, fever, weight loss, night sweats) or an abnormal CXR consistent with active TB disease, report to the County of Santa Clara Public Health Department TB Program within one day. The child will need to be evaluated for TB disease with sputum AFB smears/cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease in a patient with symptoms or signs of TB disease. The child cannot enter school unless active TB disease has been excluded or treatment has been initiated.
- If there are no symptoms or signs of TB disease and the CXR is normal, the child should be treated for latent TB infection (LTBI). Do not treat for LTBI until active TB disease has been excluded.
- Short-course regimens are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid.

Treatment Regimens for Latent TB Infection

- Rifampin 15 20 mg/kg (max. 600 mg) daily for 4 months
- 12-dose Weekly Isoniazid/Rifapentine (3HP) Regimen:
 - Isoniazid
 2-11 years old: 25 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
 ≥ 12 years old: 15 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg)
 - Rifapentine 10.0-14.0 kg: 300 mg 14.1-25.0 kg: 450 mg 25.1-32.0 kg: 600 mg 32.1-50.0 kg: 750 mg >50 kg: 900 mg
 - Vitamin B6 50 mg weekly
- Isoniazid 10 mg/kg (range, 10-15 mg/kg; max. 300 mg) daily for 9 months. Recommended pyridoxine dosage is 25 mg for school-aged children (or 1-2 mg/kg/day).
- Isoniazid and Rifampin daily for 3 months: Children: Isoniazid 10-20 mg/kg (300 mg maximum) Rifampin 15-20 mg/kg; (600 mg maximum)