NAFCC
National Association for Family Child Care

Family Child Care TB Screening

Patient completes this section

Name: _____ **Telephone: (_____)** _____
☐ **Child Care Provider** **or** ☐ **Assistant**

_____
Address **City** **State** **Zip**

TB screening status completed & signed by a health care professional

Tuberculosis shall be controlled by requiring the provider and provider assistants to have an acceptable TB screening. Please check one.

☐ **This patient has a negative TB test.** **Date of test:** _____

☐ **This patient is low risk for acquiring TB. Testing is not recommended at this time.**

☐ **This patient has a positive TB test or has had TB disease and is now free of any signs and symptoms of active TB and is cleared to work with children.**

☐ **This patient is not cleared to work with children.**

Signature of health care professional: _____ **Date:** _____

Name: _____ **Telephone: (_____)** _____

_____
Address **City** **State** **Zip**

NOTE: The TB Screening must be dated within 2 years prior to when the accreditation application is complete.