

Family Child Care TB Screening

Patient completes this section

Name: _____
 Child Care Provider or Assistant

Telephone: (_____) _____

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 is valid for 2 years