





## 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 request accreditation application is complete.