Family Child Care TB Screening

(Patient completes this section)

Name:_____

Position: ☐ Educator ☐ Assistant

Date of Birth:____/____/_____

Address _____

_____

TB Screening Status Completed & Signed by a Health Care Professional

Tuberculosis shall be controlled by requiring the educator and 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.**

I hereby attest that I have examined _____. The patient is in good health and physically able to care for children.

Signature of health care professional: _____ Date: _____

Printed Name: _____ Phone Number:_____

Address: _____

_____

NOTE: This TB Screening is Valid for 2 years.

Revised 12/2024