Shauna Ashmore
Assistant Superintendent

ACADEMICS • ACTIVITIES • SAFETY
CVUSD
CONEJO VALLEY UNIFIED SCHOOL DISTRICT

M E M O R A N D U M

To: **VOLUNTEER**

Subject: Tuberculosis (PPD) Risk Assessment

In accordance with California Education Code Section 49406, and Health and Safety Code Sections 121525-121555, the Conejo Valley Unified School District requires that persons be examined to determine if he/she is free of active Tuberculosis, no more than sixty (60) days prior to volunteering. The examination consists of a TB Risk Assessment Questionnaire certified by a health care provider, and if necessary, an intradermal Mantoux Tuberculin Skin Test (TST), which if positive (10mm or more), must be followed by a chest X-ray. If you had a positive reaction to a prior skin test, proceed with a chest X-ray.

In the case of pregnancy and an intradermal TST that is positive, an X-ray examination may be delayed until after delivery, upon request of the volunteer's physician. In the interim, the physician must certify that the volunteer shows no symptoms of Tuberculosis and to the best of his/her professional judgment, presents no health hazard to students.

The Tuberculosis Risk Assessment can be obtained at **your cost** by presenting the attached form to the medical office of your choice or to any local urgent care facility. Your own physician or any other health agency may provide proof of a current Tuberculosis clearance.

It will be your responsibility to *return* the Tuberculosis (PPD) Risk Assessment, once it is completed, ***to the school office where you plan to volunteer***. This assessment is good for four years, so you may want to make a copy for yourself.

THE TUBERCULOSIS RISK ASSESSMENT MUST BE COMPLETED BEFORE VOLUNTEERING.

FAILURE TO COMPLY WILL RESULT IN THE SCHOOL DISTRICT NOT BEING ABLE TO ACCEPT YOUR OFFER OF VOLUNTEER SERVICES.

CONEJO VALLEY UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DIVISION
1400 E. Janss Road, Thousand Oaks, California 91362
Telephone (805) 497-9511 · FAX (805) 494-3741

Student's Last Name **First Name** **Grade**

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

This form is mandatory to satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555.). Must be reviewed by *a licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)* prior to issuance of TB Clearance Certificate.

Volunteer Legal Name _____ _____ _____
LAST FIRST MIDDLE

Social Security # XXX -XX -___ ___ ___ ___ **Date of Birth** _____

Employment Type: ☐ Classified ☐ Certificated ☐ Volunteer

HISTORY OF POSITIVE TB TEST OR TB DISEASE: **YES ☐ NO ☐**

If yes, you need to submit to a symptom review and a chest x-ray (if none performed in previous 6 months) should be performed at initial hire.*
If no, respond to the risk factor questions 1—5.

RISK FACTOR QUESTIONS	YES / NO
1. **One or more signs and symptoms of TB** (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue). Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.	Yes ☐ No ☐
2. **Close contact with someone with infectious TB disease**	Yes ☐ No ☐
3. **Birth in high TB prevalence country** (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
4. **Travel to high TB prevalence country for more than 1 month** (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
5. **Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter**	Yes ☐ No ☐

⇒ If there is a "Yes" response to any of the questions 1-5 above, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

⇒ **Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.*

I hereby submit this TB Risk Assessment Questionnaire for review on _____ (date), and certify that my responses are truthful to the best of my knowledge.

_____ _____
Signature Date

AUTHORIZED HEALTH CARE PROVIDER CERTIFICATION

☐ DOES NOT HAVE TB RISK FACTORS
☐ REFERRED FOR TB SKIN TEST TB test administered on _____ ☐ Negative ☐ Positive
☐ REFERRED FOR CHEST X-RAY / FOLLOW-UP EXAM

Health Care Provider Name _____ **License No** _____

Health Care Provider Signature _____ **Date** _____