

Washington Unified School District
TUBERCULOSIS SURVEILLANCE

Name: _____ SS#: _____

Education Code 49406 specifies that all employees shall be required to undergo an examination to determine that s/he is free of active tuberculosis at least once every four years.

- For employees with previous negative skin tests a PPD skin test will satisfy this requirement obtained either at the district skin testing clinic or from the employee's primary healthcare provider.
- For employees with documented positive skin test, the primary healthcare provider's documentation of tuberculosis clearance will satisfy this requirement. The provider will determine whether a chest x-ray or a symptom review is sufficient to determine clearance.

This form is provided for the convenience of the primary care provider.

PPD SKIN TESTING	
Test Placement	
Date Applied: _____	Time: _____
0.1 ml Tubersol Lot #: _____	Expiration Date: _____
Test Reading	
Date read: _____	Time: _____
Results: _____	Induration: _____ Erythema: _____
Signature: _____	
POSITIVE SKIN TEST TREATMENT	
If skin test was positive, was an X-ray performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
X-ray results: _____	
Was prophylactic medication regimen prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
SYMPTOM REVIEW(For previous skin test converters)	
Date first time skin test was positive: _____	
Have you ever had TB? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Were you treated with medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever received BCG (a tuberculosis vaccination)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Symptoms Review. Do you have:	
A chronic cough? <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic fatigue? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Persistent night sweats? <input type="checkbox"/> Yes <input type="checkbox"/> No Involuntary weight loss? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you being treated for any serious medical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you under treatment of Prednisone, Cancer chemotherapy or xray therapy <input type="checkbox"/> Yes <input type="checkbox"/> No	

Employee free of active Tuberculosis? Yes No

Primary Care Provider's Signature: _____ Date: _____

Address: _____ Phone Number: _____