ARIZONA
DEPARTMENT OF
HEALTH SERVICES

Tuberculosis Symptom & Risk Factor Screening Tool for Child Care Staff and Volunteers

Please complete the following questions:

1. Have you ever had active tuberculosis? ☐ Yes ☐ No

2. Have you been experiencing any of the following symptoms for longer than one month?

Persistent cough:	☐ Yes	☐ No
Excessive fatigue:	☐ Yes	☐ No
Unexplained weight loss:	☐ Yes	☐ No
Coughing up blood:	☐ Yes	☐ No
Excessive night sweats:	☐ Yes	☐ No
Persistent fever:	☐ Yes	☐ No

3. Have you had close contact with anyone diagnosed with active TB disease in the past 2 years? ☐ Yes ☐ No

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Attestation

I attest that the information provided above is true and complete to the best of my knowledge. I understand that if I answered Yes to any of the above, I may be required to obtain further evaluation to rule out a communicable condition before I may begin or continue work/volunteer service.

Printed Name: _____

Signature: _____ **Date:** _____

For Facility Use Only

Reviewed by (Name/Title): _____ Date: _____

Evaluation Recommended: ☐ Yes ☐ No

Notes/Comments: