Head Start Volunteer Health / Tuberculosis (TB) Assessment

This must be completed by all "Volunteers" for Head Start.

(This is only a risk assessment tool and only a health care professional can determine if a medical condition exists that needs attention).

Volunteer Name: _____DOB: _____

1. **Are you aware of any medical condition that would prevent you from volunteering in a classroom or facility?** Yes No

2. **Have you experienced any of the following symptoms in the past 6 months?**
   - Coughing up Blood Yes No
   - Chest Pain Yes No
   - Productive prolonged cough longer than three weeks Yes No
   - Unexplained night sweats or chills Yes No
   - Unexplained weight loss / fatigue or loss of appetite Yes No

3. **Were you born in a high – risk country? (Countries other than the United States, Canada, Australia, New Zealand, or Western Countries)** Yes No

4. **Have you ever been diagnosed with tuberculosis?** Yes No

5. **Have you ever had a positive TB skin test or x-ray?** Yes No

Date Form Was Completed: _____

Note: If any questions are answered yes, follow-up must be obtained.

The area below must be completed by the doctor, health department or facility doing the follow-up:

Name of persons doing follow-up_____ Date: _____

Plan of Action if Any or Comment:

_____

_____

_____

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