

**Child name:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

**Today's date:** \_\_\_\_\_

## **TB Risk Assessment Questionnaire**

Was your child born outside the United States?

Yes	No
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Has your child traveled outside the United States?

Yes	No
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Has your child been exposed to anyone with TB disease?

Yes	No
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Does your child have close contact with or live with a person who has a positive TB skin test?

Yes	No
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