INLAND URGENT CARE

Inland Urgent Care

36320 Inland Valley Dr., Suite 307
Wildomar, CA 92595
951-600-0110 phone
951-600-1489 fax

29738 Rancho California Road, Ste B
Temecula, CA 92591
951-303-6440 phone
951-303-6449 fax

27168 Newport Rd., Suite 1
Menifee, CA 92584
951-246-3033 phone
951-246-7373 fax

VOLUNTEER T.B. RISK ASSESSMENT AUTHORIZATION

Schedule an appointment at one of the Inland Urgent Care locations.
Walk-In visits are not recommended due to possible extended wait times.

Please present this form to Inland Urgent Care upon arrival, to receive a TVUSD discount rate.

PATIENT NAME ____________________ ____________________ ____________________
FIRST **MIDDLE** **LAST**

ADDRESS ____

CITY ____________ **STATE** ____________ **ZIP** __________ **DOB** __________

WORK PHONE ________________ **CELL** ____________________

IF YOU HAVE HAD A POSITIVE SKIN TEST, YOU WILL NEED A CHEST X-RAY. NO EXCEPTIONS.

Assembly Bill 1667 replaces mandated TB examination (within the last four years) of volunteers with "frequent or prolonged contact with pupils" in private or parochial elementary or secondary schools, or nursery schools (California Health and Safety Code, Section 121545) with a TB risk assessment questionnaire administered on initial volunteer assignment and every four years.

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the attending Physician. I hereby authorize the Physician to release any information acquired in the course of the examination or treatment to Temecula Valley Unified School District. **Note: TVUSD does not cover the cost of services incurred for the purpose of a TB clearance.**

I have read and understand the above conditions and will comply. **PRINT NAME**______________________________

SIGNATURE____ **DATE**____/____/____

(OFFICE USE ONLY)
Administration site: [ ] Rt. Forearm [ ] Lt. Forearm Mfg.__________**Lot**__________**Exp**____/____/____

This is to certify that the above patient has received the TPPD MANTOUX (PPD) T.B. skin test on:

This test was administered ____/____/____ **at** ____:____ **hours**

Red Hawk Elementary
32045 Camino San Jose
Temecula, CA 92592

by____
NAME **TITLE** **SIGNATURE**

The result of the above test was read on:

____/____/____ **at** ____:____**hours and the results were [ ] positive [ ] negative**

READ BY:____
NAME **TITLE** **SIGNATURE**

CHEST X-RAY RESULTS WERE READ ON:
____/____/____ **at** ____:____**hours and the results were [ ] positive [ ] negative [ ] No x-ray taken**

READ BY:____
NAME **TITLE** **SIGNATURE**

Revised: 1/2017

SCHOOL STAMP IS TO BE VISIBLE ON THE FRONT OF THE AUTHORIZATION FORM

Volunteers

School Site: ______________________

Adult Tuberculosis (TB) Risk Assessment Questionnaire[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)

Name: ______________________ Date of Risk Assessment: ______________________

Date of Birth: ______________________

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History of positive TB test or TB disease Yes ☐ No ☐

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.*

If no, continue with questions below.

If there is a "Yes" response to any of the questions 1-5 below, 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.

Risk Factors	
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.[2]	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 ☐

**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.*

[1] Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

[2] Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013. (http://www.cdc.gov/tb/publications/LTBI/default.htm)

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

CERTIFICATE OF COMPLETION

To be signed by the licensed health care provider completing the risk assessment and/or examination

Name: ______________________________ **Date:** ______________________________

Date of Birth: ______________________________

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

____

Health Care Provider Signature

____

Please Print Health Care Provider Name **Title**

____

Office Address: Street **City** **State** **Zip Code**

____

Telephone **Fax**

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