Dear Parent/Guardians:

The health and well-being of your child is our number one priority. Please help assist our staff by following the guidelines and policies that have been approved by our Board of Education.

When a child is absent from school, the parent/guardian **must telephone the school office/nurse's office by the start of the school day.** Each school has a voice mail system that is on 24/7.

If your child has a **fever over 100 degrees,** he/she will be sent home and/or should remain out of school until the temperature has been normal for 24-hours without medication.

If your child is **vomiting or has diarrhea,** he/she will be sent home and/or should remain out of school until 24-hours after the episodes have ceased.

If a child is diagnosed with a **communicable bacterial infection** such as Strep Throat, "Pink-eye", etc., that child must **remain out of school for at least 24 hours after starting antibiotic therapy.**

Please call the nurse's office if your child has been diagnosed with communicable conditions such as chicken pox, impetigo, scabies, fifth disease, strep or pink-eye. Please also alert the school nurse if you suspect a case of lice.

Any medication that must be taken during school hours, either prescription or over-the-counter, requires doctor's orders to be on file in the nurse's office. This includes, and is not limited to, Tylenol, Ibuprofen, cough syrup, cough drops, topical creams, etc. Region 16 medication forms are available in this packet, in the nurse's offices and separately on the Region's web site. They must be completed and signed by a physician and by parents/guardians each school year. An adult must bring all medication, along with the appropriate orders to the School Nurse in the original container, labeled with the child's name and directions for dispensing the medication.

In the Elementary Schools, children are not allowed to have any medication, including but not limited to, cough drops, throat lozenges, etc., on their person at any time.

In the Middle School and High School, students are not allowed to have any medication, including but not limited to, cough drops, throat lozenges, etc., on their person at any time unless **a physician has indicated self-administration** is approved on the medication orders, the parent/guardian indicates permission with their signature, and the School Nurse has signed off on the orders.

If a student must be in school with a medical device (such as heart monitors, casts, elastic bandages, splints, crutches, etc.) please provide **written instructions from the physician along with activities that are allowed or restricted.**

If your child has a **medical condition** such as diabetes that requires intervention by the School Nurse, doctor's orders, medications and supplies must be provided before the beginning of each school year.

Students new to the Region must supply a c**ompleted health assessment and record of immunizations** prior to starting school. Please send copies of the yearly updates and records of any new immunizations or changes in your child's medical status as they occur.

If your child has a **food allergy** please contact your School Nurse for a food allergy packet. The packet is also available on the Region's web site.

Because so many of our students have food allergies, all ingredients of any foods sent into the classroom for celebrations must be identified. That means no homemade food and we prefer individually wrapped items, unopened and purchased from a licensed food vendor.. **You will receive a letter at the beginning of the school year alerting you to any food allergies in your child's classroom (Elementary Schools).**

If your child has **asthma** and needs a rescue inhaler during the school day, doctor's orders, an asthma action plan and the inhaler must be brought to the School Nurse.

For a **confirmed case of lice,** the student must be brought to the School Nurse to be checked before returning to school after the initial treatment. The child should be retreated after 10-days and will then be rechecked by the School Nurse. If evidence of lice is discovered at any time, the child will have to be removed from school as Region 16 has **No Nit Policy**.

Latex products such as balloons are not allowed on school property. Many people are developing latex allergies and in the younger grades, there is also a danger of aspiration with any balloons.

REGION 16
Partnership for Excellence
BEACON FALLS & PROSPECT

REGIONAL SCHOOL DISTRICT #16
BEACON FALLS and PROSPECT

HEALTH REQUIREMENTS

In order to be admitted into the school setting, please be sure that you have the necessary paperwork and all immunizations are up-to-date. Please review the immunizations required on the attached form.

A copy of your child's immunization record must be on file on, or prior to, the first day of school so that the School Nurse can be sure that all immunizations are up-to-date.

A physical exam is required for all students entering Preschool, Kindergarten, entering Seventh and Tenth Grades. Please be sure that your physician completes all the starred (*) items including vision, hearing and the required blood work. This is mandated by Connecticut State Statutes.

All children entering Region #16 from out-of-state are required to submit a physical that has been done within the past year. For example, if you are entering in the month of September, the physical can be from September of the previous year. A new physical from a Connecticut physician or clinic must be submitted within the school year after entering. Doctor's orders for medication from another state will not be accepted.

Children transferring from another Connecticut school system are not required to submit a physical unless they are entering a grade that requires an updated physical. In this case, the physical should be completed before entering school.

Children entering from out-of-the-country must have proof of immunizations, a recent physical done in the United States and proof of Tuberculin testing if coming from a high risk country.

If your child will need medication during the school day, authorization for school personnel to administer medication must be filled out and signed by a physician, signed by parents and brought to the School Nurse along with the medication. **Students in the Elementary Schools are prohibited from carrying medication on them at all times.** Students in the Middle and High Schools may carry medication if they have a self-carry order on file in the Nurse's Office.

Please contact the School Nurse at your child's school if there are any health related issues that they should be aware of or if you have any medical concerns.

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS

2019-2020 SCHOOL YEAR

PRESCHOOL

DTaP:	4 doses (by 18 months for programs with children 18 months of age)
Polio:	3 doses (by 18 months for programs with children 18 months of age)
MMR:	1 dose on or after 1st birthday
Hep B:	3 doses, last one on or after 24 weeks of age
Varicella:	1 dose on or after 1st birthday or verification of disease
Hib:	1 dose on or after 1st birthday
Pneumococcal:	1 dose on or after 1st birthday
Influenza:	1 dose administered each year between August 1st-December 31st (2 doses separated by at least 28 days required for those receiving flu for the first time)
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

KINDERGARTEN

DTaP:	At least 4 doses. The last dose must be given on or after 4th birthday
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
Hib:	1 dose on or after 1st birthday for children less than 5 years old
Pneumococcal:	1 dose on or after 1st birthday for children less than 5 years old
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADES 1-6

DTaP/Td:	At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADE 7

Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
Meningococcal:	1 dose
Hep B:	3 doses, last dose on or after 24 weeks of age
Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease
Hepatitis A:	2 doses given six calendar months apart, 1st dose on or after 1st birthday

Revised 1/3//2019

GRADES 8-12	Tdap/Td:	1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
	Polio:	At least 3 doses. The last dose must be given on or after 4th birthday
	MMR:	2 doses separated by at least 28 days, 1st dose on or after 1st birthday
	Meningococcal:	1 dose
	Hep B:	3 doses, last dose on or after 24 weeks of age
	Varicella:	2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease

- DTaP vaccine is not administered on or after the 7th birthday.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated.
- Hib is required for all Pre-K and K students less than 5 years of age.
- Pneumococcal Conjugate is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2019-2020 applies to all Pre-K through 7th graders born 1/1/07 or later.
- Hep B requirement for school year 2019-2020 applies to all students in grades K-12.
  Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 must be administered at 24 weeks of age or later.
- Second MMR for school year 2019-2020 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2019-20 applies to all students in grades 7-12
- Tdap requirement for school year 2019-2020 applies to all students in grades 7-12
- If two live virus vaccines (MMR, Varicella, MMRV, Intra-nasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for Hep A, Hep B, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

For the full legal requirements for school entry visit:
https://portal.ct.gov/DPH/Immunizations/Immunization--Laws-and-Regulations

If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including **all** preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All pre-schoolers, as well as all students entering kindergarten**, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, **are considered new entrants**. The one exception is students returning from private approved special education placements–they are not considered new entrants.

Commonly Administered Vaccines:

Vaccine:	Brand Name:	Vaccine:	Brand Name:
DTaP-IPV-Hib	Pentacel	MMRV	ProQuad
DTaP-HIB	TriHibit	PCV7	Prevnar
HIB-Hep B	Comvax	PCV13	Prevnar 13
DTaP-IPV-Hep B	Pediarix	DTaP-IPV	Kinrix, Quadracel
Hepatitis A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Fluarix, FluLaval Flucelvax, Afluria

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone / Cell Phone	
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N Does your child have dental insurance? Y N Does your child have HUSKY insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name _____ Birth Date _____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT_____in/cm_____% *Weight_____lbs._____oz /_____% BMI____/____% *HC_____in/cm_____% (Birth – 24 months) *Blood Pressure_____/____ (Annually at 3 – 5 years)

Screenings

*Vision Screening
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess
❑ Referral made to: _____

*Hearing Screening
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess
❑ Referral made to: _____

*Anemia: at 9 to 12 months and 2 years

*Hgb/Hct: | *Date

*Lead: at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑ No ❑ Yes

*TB: High-risk group? ❑ No ❑
Yes Test done: ❑ No ❑ Yes Date: _____
Results: _____
Treatment: _____

*Dental Concerns ❑ No ❑ Yes
❑ Referral made to: _____
Has this child received dental care in the last 6 months? ❑ No ❑ Yes

*Result/Level: *Date

Other:

*Developmental Assessment: (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*IMMUNIZATIONS ❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

*Chronic Disease Assessment:

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: _____
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II
Seizures ❑ No ❑ Yes: Type: _____

Other Chronic Disease: _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑ No ❑ Yes This child may fully participate in the program.
❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Child's Name: _____ **Birth Date:** _____ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Date: _____

STUDENT INFORMATION SHEET
(Please fill out both sides completely)

PLEASE PRINT

LAST NAME _____ GRADE _____

FIRST NAME _____ MIDDLE NAME _____

ADDRESS _____

CITY/STATE _____ ZIP _____

PHONE _____ BIRTHDATE _____

PARENT/GUARDIAN INFORMATION

FIRST CONTACT – PARENT/GUARDIAN

Does this person have legal custody? Y N

NAME _____

ADDRESS _____

Place of Employment _____

SECOND CONTACT – PARENT/GUARDIAN

Does this person have legal custody? Y N

NAME _____

ADDRESS _____

Place of Employment _____

PLEASE INCLUDE AREA CODES WITH ALL PHONE NUMBERS

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

EMAIL _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

EMAIL _____

LIST OF ADULTS PERMITTED TO REMOVE CHILDREN FROM SCHOOL

NAME _____

PHONE _____

RELATIONSHIP TO CHILD _____

NAME _____

PHONE _____

RELATIONSHIP TO CHILD _____

NAME _____

PHONE _____

RELATIONSHIP TO CHILD _____

NAME _____

PHONE _____

RELATIONSHIP TO CHILD _____

NAME _____

PHONE _____

RELATIONSHIP TO CHILD _____

NAME _____

PHONE _____

RELATIONSHIP TO CHILD _____

NAME _____

PHONE _____

RELATIONSHIP TO CHILD _____

PARENT/GUARDIAN SIGNTAURE _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

Signature of Parent/Guardian _____

Is your child on medication: Yes _____ No _____

Name of medication(s): _____

Reason for medication(s): _____

Medication Allergy: _____

Bee Sting Allergy: Yes _____ No _____ Epi-Pen in school: Yes _____ No _____

Asthma: Yes _____ No _____

Diabetes: Yes _____ No _____

Seizures: Yes _____ No _____ Type _____ # occurrences _____

Food Allergies: Yes _____ No _____

Measures to take if ingested (i.e. Benadryl, Epi-Pen):_____

Physician's Name_____

Address_____

City/State/Zip _____

Please feel free to use the space below to include any medical, social, emotional or physical information concerning your child that you feel might impact his/her educational process:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Risk Assessment Questionnaire

For Tuberculosis Exposure

1. Was your child born outside the US?
   If yes, where was your child born? If born in Africa, Asia (including the former Soviet Union), Latin America (including Haiti and the Dominican Republic) or Eastern Europe, a TST (TST=Tuberculin Skin Test) should be placed.

2. Has your child traveled outside the US?
   If yes, where did the child travel, with whom did the child stay, and how long did the child travel? If the child traveled to any of the above continental areas, stayed for;:: 1 week and interacted with the local people, including local friends or local family, then a TST should be placed.

3. Has your child been exposed to anyone with TB disease?
   If yes, determine whether the person had TB disease or L TBI, when the exposure occurred, and what the nature of the contact was. If confirmed that contact was with a person with known or suspected TB disease, a TST should be placed.

4. Does your child have close contact with someone with a positive TST?
   If yes, see previous question for follow-up questions.

5. Does your child spend time with anyone who has been in jail (or prison) or a shelter, inj ects illegal drugs, or has HIV?
   If yes, then a TST should be placed

6. Has your child consumed raw milk or eaten unpasteurized cheese since the last tuberculin skin test?
   If yes, then a TST should be placed.

7. Does your child have a household member who was born outside the US?
   If yes, from what country? If country is one of the countries included in question #1, then a TST should be placed.

8. Does your child have a household member who has traveled outside the US?
   Included as a household member are persons who take care of the child in the home. If yes, and the person is from one of the countries included in question 1, a TST should be placed.

[1] All countries in Africa, Asia (including former Soviet Union), Eastern Europe, Central and South America, Dominican Republic and Haiti.

Student Name: _____ Date of Birth: _____