



NeighborImpact

Head Start

Please print TB Screening form. Fill out the form, sign and bring it in on your first day of volunteering. If you have question, please email Volunteer@NeighborImpact.org.

Tuberculosis Screening

Volunteer Name: _____
(please print)

1. In the past year have you traveled outside the United States? No Yes

If yes, please list where you went to visit _____

2. Have you knowingly been exposed to TB? No Yes

3. Do you suffer from night sweats? No Yes

4. Do you have unexplained fevers? No Yes

5. Have you experienced a prolonged cough? No Yes

6. Have you experienced unexplained weight loss? No Yes

7. Have you experienced chest pains? No Yes

I understand that any positive answers will be reviewed by the Head Start RN Consultant.

Volunteer Signature: _____ Date: _____