NeighborImpact

Critical Needs. Diverse Services. Empowering Change.

Head Start

Tuberculosis Screening

Volunteer Name: _____

Date: _____

1. In the past year have you traveled outside the United States? ☐ No ☐ Yes
   If yes, please list the areas travelled to: _____
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

Volunteer Signature: _____

I understand that any positives will be reviewed by the Head Start Health Service Manager.

Submitted to the Head Start Volunteer Coordinator for Review. Document will be held by the Volunteer Coordinator after Review.