



LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

ATTACHMENT J



Adult Tuberculosis (TB) Risk Assessment Questionnaire¹

(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: _____

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 <input type="checkbox"/> No <input type="checkbox"/>
2. Close contact with someone with infectious TB disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes <input type="checkbox"/> No <input type="checkbox"/>

*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>)

TCB-01 (12/14) Effective January 1, 2015

Do Not Submit Adult Tuberculosis (TB) Risk Assessment Questionnaire to LAUSD



LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

ATTACHMENT J



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 _____

TCB-01 (12/14) Effective January 1, 2015



LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN

ATTACHMENT C1



LAUSD VOLUNTEER COMMITMENT FORM

(Tier I, Tier II and Tier III Volunteers must read and sign this form)

Print First and Last Name

School or Office Name

I agree to abide by the following:

1. I will sign in at the main office upon arrival and sign out when I leave for the day.
2. I will follow the assignment schedule given to me by the principal or designee.
3. I will use words and phrases that are appropriate and be a good role model for students.
4. I will wear my volunteer identification badge at all times while participating in volunteer activities.
5. Except in the case of an emergency, I will give 24-hour notice when I cannot keep a scheduled assignment.
6. I will follow the dress code of the school or office.
7. I will follow the District's Code of Conduct with Students and the District's Employee Code of Ethics.
8. I will only use the adult bathroom facilities.
9. I will never be alone with a student.
10. I will not contact students outside of school hours, or exchange contact information.
11. If I have reason to suspect child abuse, I will notify the principal or designee immediately and confidentially.
12. I will treat all students, families, and employees with respect regardless of their race, gender, class, religion, sexual orientation, gender identity, disability, or immigration status.
13. I will treat all children and persons equally and with respect.
14. I will maintain strict confidentiality of students' health, behavior and academic information.
15. I will maintain strict confidentiality of parent/guardians' health, behavior and information.
16. I will report inappropriate behavior to the teacher or other supervising school personnel.
17. I will respect the authority of all school and office personnel.
18. I will learn the rules regarding drills and emergencies and follow the direction of District office or school staff.
19. I will not use school property or equipment without the authority of the administrator or designee and I will not use school property or equipment for personal gain.

Volunteer's Signature

Date

Administrator or Designee's Signature

Date



**LOS ANGELES UNIFIED SCHOOL DISTRICT
POLICY BULLETIN**

ATTACHMENT II

**Los Angeles Unified School District
TUBERCULOSIS PHYSICIAN/CLINIC FORM**

Dear Prospective Volunteer:

Thank you for your interest in volunteering at our school. Volunteers must be free of active tuberculosis (TB) before they start volunteering. A TB skin test (Mantoux) is mandatory, as stated in California Health and Safety Code §121545 TB Test School Volunteers. Multiple puncture tests are not acceptable. If the Mantoux test is positive, a chest X-ray will be required. Chest X-rays without a history of a previous positive Mantoux cannot be accepted.

Please take this form to a private physician, clinic, or public health agency. If you are unable to pay the fee required by a public health agency, you may request to have the fee waived by the agency. If denied a waiver, you are still responsible for any costs incurred.

Principal or District Office Administrator Signature Date

School or Office: _____

TO BE COMPLETED BY PHYSICIAN/CLINIC:

Patient's Name: _____ Date of Birth: _____

THERE IS NO EVIDENCE OF ACTIVE TUBERCULOSIS AS DETERMINED BY:

_____ TB Risk Assessment Questionnaire administered by a licensed health care provider

_____ MANTOUX Skin Test (5 TU PPD)

_____ CHEST X-RAY (Acceptable only if MANTOUX positive)

Date Given: _____ Date Read: _____ Date of X-Ray: _____

Given by: _____ Result (mm): _____

X-Ray Impression: _____

History of positive MANTOUX: _____

Signature of Physician/RN Date

Print Name of Physician/RN: _____ Degree: _____ State License #: _____

Business Address: _____

Business Telephone: _____