SANTA MONICA-MALIBU UNIFIED SCHOOL DISTRICT

Tuberculosis Questionnaire and Emergency Contact Information for Volunteers

Name: _____ Date of Birth: _____ Date: _____

Address: _____

Phone Number: _____ Email: _____

Notify in Case of Emergency: _____ Relationship: _____ Phone: _____

Please complete this form and submit it to the school Registered Nurse who will conduct the California School Employee Tuberculosis (TB) Risk Assessment Questionnaire and complete the Certificate of Completion Tuberculosis Risk Assessment and/or Examination form.

Please note: *The California Health and Safety Code, Section 121525-121555, and the California Education Code, Section 49406 require volunteers to document tuberculosis clearance within sixty (60) days before starting and every four* years *thereafter. The volunteer will be required to have the Adult Tuberculosis Risk Assessment Questionnaire administered by* a *licensed health care provider (including* a *school nurse). Repeat risk* assessments *should occur every four* years *(unless otherwise required) to identify any additional risk factors, and TB testing based on the results of the TB risk* assessment. *Retesting for previously certified volunteers should only be done in persons who previously tested negative and have new risk factors since the last assessment. Previously certified volunteers who have* a *documented history of* a *positive TB test or* a *TB infection, and previously submitted* a *chest x-ray that* was *determined to be free of infectious TB, are not required to submit* a *new chest x-ray if there are no new risk factors.*

I certify to the best of my knowledge:

1. I have been **previously certified as a volunteer for SMMUSD**: ☐ Yes ☐ No
   a. If yes, year of last certification: _____
   b. If yes, school site of last certification: _____
2. I have had a **positive TB test or active TB in the past**: ☐ Yes ☐ No
   a. If YES, date of positive TB test or active TB: _____
   b. If YES, date of last chest x-ray: _____
3. I have **one or more signs or symptoms of TB** (prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue): ☐ Yes ☐ No
4. I have had **close contact with someone with infectious TB** disease in my lifetime ☐ Yes ☐ No
   a. If YES, year of close contact: _____
5. I was born **OUTSIDE of the USA/ Canada**: ☐ Yes ☐ No
   a. If YES, name of country: _____
6. I have **traveled/resided outside the USA/ Canada for more than 1 month**: ☐ Yes ☐ No
   a. If YES, name of country with dates of travel: _____

I hereby swear and affirm that all answers and statements herein contained are true, and I agree and understand that any misstatements of material facts contained in this application will cause forfeiture upon my part of all rights to volunteer, either present or future, in the services of the Santa Monica - Malibu Unified School District.

Date: _____ Signature of Applicant: _____