



**FOOD WORKERS PERMIT SCHOOL**  
*Please Print in Ink*

Please indicate which card you would like: \_\_\_\_\_ State-Wide Card (valid for 2 years) **\$20**  
\_\_\_\_\_ Barbour County Card (valid for 2 years) **\$10**

Class Date \_\_\_\_\_ Last 4 Digits of Social Security Number \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
First Last

Mailing Address \_\_\_\_\_  
\_\_\_\_\_

Place of Employment \_\_\_\_\_ Location of Employment \_\_\_\_\_

Position Held: \_\_\_\_\_ Owner \_\_\_\_\_ Manager \_\_\_\_\_ Cook \_\_\_\_\_ Other \_\_\_\_\_

**OFFICE USE:**

Check: \_\_\_\_\_ Cash: \_\_\_\_\_

**TB Risk Assessment**

Patient name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Date: \_\_\_\_\_

<b>SYMPTOMS:</b>	YES	NO
<b>Does the patient have any of the following symptoms?</b> <i>(If you mark yes to any of following symptom questions please report the findings immediately to the WV Division of TB Elimination)</i>		
Cough for more than 2-3 weeks		
Hemoptysis (Coughing up blood)		
Fever		
Weight loss of more than 10 lbs. for no known reason		
Loss of appetite		
Night sweats		
Weakness or extreme fatigue		

<b>RISK FACTORS:</b>	YES	NO
<b>Does the patient have any of the following risk factors?</b> <i>(If you mark yes to any of the following risk factor questions, the patient is qualified for state funded testing)</i>		
Recent contact to someone with active TB		
Born in a country other than the U.S. If yes, what country? _____		
Visited another country and stayed for 2 months or more If yes, what country? _____		
Lived in another country If yes, what country? _____		
Ever lived or worked in a prison, jail or homeless shelter		
Ever worked in a healthcare facility (including long-term care) outside of West Virginia If yes, where? _____		
Ever injected drugs not prescribed by a doctor		
Currently or ever reported having any of the following medical conditions: <i>(please check all that apply)</i> ___ Diabetes                      ___ Stomach or intestinal surgery                      ___ HIV ___ Kidney disease                      ___ Chronic lung disease                      ___ Colitis ___ Cancer                      ___ Rheumatoid arthritis		
Currently taking or planning to take any medication that their doctor has said could weaken their immune system or increase their risk for infection  <i>(Examples: chemotherapy, some rheumatoid arthritis medications, organ anti-rejection drugs, some medication to treat skin disorders, etc.)</i>		

Patient name: \_\_\_\_\_

<b>TB HISTORY:</b>	YES	NO
<b>Has the patient ever had any of the following?</b>		
Ever had a TB skin test: If yes: When _____ Where _____ Result _____		
Ever had a TB blood test: If yes: When _____ Where _____ Result _____		
Taken the BCG vaccine <i>(If you mark yes to this question the patient should only receive a TB blood test, DO NOT use PPD for testing)</i>		
Been treated with BCG for cancer <i>(If you mark yes to this question the patient should only receive a TB blood test, DO NOT use PPD for testing)</i>		
Ever taken medication for TB in the past		
Ever been diagnosed with TB in the past		

<b>REASON FOR TESTING:</b>	YES	NO
<b>What prompted testing today?</b>		
Employer requirement		
Educational institution requirement		
Doctor requires testing prior to starting a medication		
Other (please specify):		

<b>FOR LHD OFFICE USE:</b>			
NURSE SIGNATURE: _____		DATE: _____	
_____ State TST	_____ State IGRA	_____ Private TST	_____ Private IGRA
_____ CXR	_____ Diagnostic Clinic	_____ Sputum X 3	
_____ Letter Given	_____ No Follow-Up Needed		