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:__________

West Virginia Department of Health and Human Resources
Division of Tuberculosis Elimination
TB Risk Assessment

Patient name: ______________________________ **Birth date:** _________ **Date:** _________

Do you have any of the following symptoms? (Please indicate by circling yes or no to each)

Yes *No* Cough (Longer than 3 weeks)
Yes *No* Fever
Yes *No* Coughing up blood
Yes *No* Loss of weight
Yes *No* Loss of appetite
Yes *No* Night sweats
Yes *No* Fatigue

Were you born in another country? (Please indicate by circling yes or no)

Yes *No* Please indicate the country: ____________________________________

Have you? (Please indicate by circling yes or no to all)

Yes *No* Had a recent contact with someone with active TB?
Yes *No* Recently or currently been homeless? (within the past 2 years)
Yes *No* Visited another country for 2 months or more?
Please indicate the country: ____________________________________
Yes *No* Lived in another country?
Please indicate the country: ____________________________________
Yes *No* Taken the BCG vaccine?

Are you? (Please indicate by circling yes or no to all)

Yes *No* A student who is entering the public or private school system and moved to WV within the past 4 months?
Yes *No* A volunteer or new personnel entering the WV school system for the first time?

Have you had? (Please indicate by circling yes or no to all)

Yes *No* Cancer of the head and/or neck?
Yes *No* Leukemia?
Yes *No* Any other form of cancer?

Do you now have or have you had a history of? (Please indicate by circling yes or no to all)

Yes *No* A positive TB skin test?
Yes *No* A known risk for HIV?
Yes *No* Diabetes?
Yes *No* Silicosis or black lung?
Yes *No* Kidney disease?
Yes *No* Intestinal bypass surgery?
Yes *No* Gastrectomy surgery?
Yes *No* An impaired immune system?
Yes *No* A disease that requires medications that decrease your immune system?

I am requesting a TB test because: (Please indicate by circling yes or no to each)

Yes *No* My employer requires me to have this test.
Yes *No* My education institution requires me to have this test.
Yes *No* Other reason: ______________________________

Name of Employer or Education Institution: ______________________________

____

FOR OFFICE USE ONLY

NURSE SIGNATURE:______________________________ DATE:____________________

_______TST _______IGRA _______CXR _______DIAGNOSTIC CLINIC _______NO FOLLOW-UP NEEDED _______LETTER GIVEN

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WVDHHR/DTBE
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