



**FREMONT COUNTY DEPARTMENT OF
PUBLIC HEALTH & ENVIRONMENT**

201 N. 6th Street
Cañon City, CO 81212
P: 719-276-7450 F: 719-276-7451

Tuberculosis (TB) Risk Assessment & Authorization

Name: _____ Date of Birth: _____ M: _____ F: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Type of Phone (Circle one): Home Cell Work

- Are you from or have you lived for two months or more in Africa, Asia, Central or South America, or Eastern Europe?**
Yes No If yes, list countries _____
- Have you been diagnosed with a chronic condition that may impair your immune system?** Yes No
If yes, check all that apply
Chronic Steroid Use Gastrectomy/Intestinal Bypass Diabetes Mellitus
HIV Infection Crohn's I
Disease Dialysis/ Renal Failure
Cancer of the head or neck Rheumatoid Arthritis Silicosis
Chronic Malabsorption Syndromes Use of TNF-A Antagonist Low Body Weight
Leukemia Other _____
- Have you ever resided, worked or volunteered in any of the following facilities?** Yes No
Prison Hospital Nursing Home
Homeless Shelter Other long term treatment center _____
- Do you currently have any of the following symptoms?** Yes No
Productive Cough (coughing up something) Cough >3weeks Unexplained Fever Chills
Respiratory Difficulty (shortness of breath) Night Sweats Loss of Appetite Weakness
Unexplained Weight Loss Coughing up blood Chest Pain Fatigue
- Have you ever had contact with a person known to have active Tuberculosis?** Yes No
- Have you had a tuberculin skin test before?** Yes No If yes..... Positive Negative
- Have you had any vaccines in the past 4 weeks?** Yes No If yes, what vaccines? _____

By signing below, I acknowledge that I am responsible for payment of fees associated with this assessment and have been notified in advance as to the amount of these fees. I have received a copy of the "TB Elimination- Tuberculin Skin Testing" handout published by the CDC, and I have had a chance to ask any questions which were answered to my satisfaction. I give Fremont County Department of Public Health & Environment permission to administer and read a Tuberculosis (TB) test. **I attest that the above information is true and complete to the best of my knowledge, and I am aware that deliberate misrepresentation may jeopardize my health.**

Patient/Parent Signature: _____ Date: _____

FCDPHE OFFICE USE ONLY

Manufacturer: _____ Lot #: _____ Site: _____
Administered By: _____ Date: _____

Read Date: _____ Result: _____ Induration: _____
Read By: _____ Date: _____

Fee (eff. 8/1/2021): \$20.00 Date Rec'd: _____ By: _____