**NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT**

# Consent for Tuberculin Skin Test and Child Find Screening Procedures

All school districts across our nation have a "Child Find" program, which looks for potential health problems that may affect student learning. Annually, Northwest Arctic Borough School District (NWABSD) personnel and Maniilaq Public Health Nursing combine their efforts to provide school screenings.

This year, the screenings will take place in the **Fall of 2011** and the **Spring of 2012**. Tuberculin (TB) skin testing is required for children to enter school each year and is mandated by Alaska State Law (7AAC 27.213). Additional components (for specified age groups) include screenings for hearing and vision. All information found on school screenings will be shared between PHN and the NWABSD.

PERTINENT MEDICAL HISTORY (for example: allergies to foods, medications, alcohol; asthma; seizures; diabetes; current medications, etc)

Please **initial** the appropriate section below:

_____ I give my consent for my child (named above) to have a **complete school screening,** this includes the Tuberculin (TB) skin test and the other exams and screenings listed above.

_____I give consent for my child (named above) to have all the tests **except** the Tuberculin (TB) skin test. Reason for not giving consent:_____

_____ I **do not** give my consent for my child (named above) to have the Tuberculin (TB) skin test or any of the other PHN screens. Reason for not giving consent: _____

**By signing below, you are giving your consent to the screenings described above and for the information to be shared with the Northwest Arctic Borough School District.**

_____ _____

**Signature of Parent or Guardian** **Date**

**NOTICE OF PRIVACY PRACTICES**

**Before being seen by Maniilaq Public Health Nursing (PHN), the law requires that we explain your patient rights and responsibilities, including our Privacy Practices. By signing below you are acknowledging that you have received the enclosed brochure "Notice of Privacy Policies for Maniilaq Health Center."**

_____ _____

**Signature of Parent or Guardian** **Date**

**NAME:** _____ **DOB:** _____ **TEACHER:** _____

**GENDER: Male Female** **VILLAGE:** _____ **GRADE:** _____

**CHILD FIND VISION SCREENING**

| RIGHT | LEFT |
|---|---|
| 20/ | 20/ |

**With / without** glasses or contact, please circle one

**HEARING SCREENING @ 20 dB**
Grades K, 3, 6, & 9

| | 500 | 1000 | 2000 | 4000 |
|---|---|---|---|---|
| RIGHT | + / - | + / - | + / - | + / - |
| LEFT | + / - | + / - | + / - | + / - |

**PHN TB TEST**

| DATE PLACED | SITE | DATE READ | RESULTS |
|---|---|---|---|
| - - 2011 | RA / LA | - - 2011 | MM |

| REFERALS PHN USE ONLY |
|---|
| EYE CLINIC_____ |
| AUDIO CLINIC_____ |
| SCHOOL RECHECK___ |

I: PHN Forms Folder: School Screening Form

_____

PHN Signature