

COMMUNICABLE DISEASE

As part of the School Health Service program, a free Tuberculin screening will be offered to students in grades 4, 8, and 12.

Please fill out the following form and indicate by checking yes or no if you wish your child to participate.

You will be contacted if your child has a Positive reaction.

Home _____

Student's Name _____

Phone _____

Teacher or Home Room _____

Date of last Tuberculin Test _____ Reaction _____

Please list any immunizations your child has received in the past 30 days:

Permission Granted Yes ___ No ___

Parent's Signature _____

Date _____

SCHOOL HEALTH SERVICE

CHILD'S NAME _____ SCHOOL _____

TEACHER _____ GRADE _____ DATE _____

DEAR PARENT: Your child's throat has been cultured at school by the school Nurse. A germ (streptococcus) has been found that may lead to rheumatic fever or kidney infection if it is not destroyed. It is important that your child receive immediate treatment. Please see your family physician at once and take this notice with you for his signature.

Your child must have this signed notice to be readmitted to school. Please return this notice to the School Nurse.

Thank you.

PHYSICIAN'S SIGNATURE _____

TREATMENT GIVEN _____

DATE OF TREATMENT _____

See policy JHCC

First Reading: September 14, 2010
Second Reading: October 12, 2010
Final Adoption: October 12, 2010