

Your Child's Name: _____

Does your tap water contain fluoride? Yes No Unsure

Is your child on any medications or supplements, including vitamins? If so, please list below:

Risk Assessment for Tuberculosis Exposure/Infection:

Has a family member or contact had tuberculosis disease? Yes No

Has a family member had a positive tuberculin skin test? Yes No

Was your child born in a high-risk country?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes NoHas your child traveled to (or had contact with people
who live in) a high-risk country for more than one week?
(Countries **other** than the United States, Canada,
Australia, New Zealand, or western European countries) Yes NoDo you have any concerns about your child's development, or any
other concerns you would like to discuss with your provider? Yes No*If so, what are your concerns?*