Maui Adult Day Care Centers

Annual TB Clearance

11 Mahaolu Street, Suite B
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Tel: (808) 871-5804 / Fax: (808) 877-4082

☐ Kahului Facility ☐ Ocean View Facility ☐ West Maui Facility ☐ South Maui Facility

I. PERSONAL INFORMATION (Part I to be completed by the caregiver)

Name: _____ Date: _____

Birthdate: _____ Gender: _____

II. TUBERCULOSIS TEST CLEARANCE (Part II to be completed by the examiner)
Provide information below or attach a TB Clearance

☐ **TB Skin Test:**

TST is valid for 12 months from the date of reading and is updated annually.

Date Given: _____ **Date Read:** _____ **Result:** _____

☐ **Chest X-ray:**

- A chest X-Ray is to be taken every 10 years.
- The screening form below must be completed when using a chest X-Ray for clearance.
- Screening clearance is valid for 12 months from the date of screening and is updated annually.

Symptom TB Screening: (must be completed)	**Yes**	**No**
1. Chronic Cough (> 3 weeks duration)		
2. Fever		
3. Night Sweats		
4. Unintentional weight loss >10% of body weight		
5. Hemoptysis		
6. Malaise/Fatigue		

Date of Chest X-ray: _____ **Date of Screening:** _____ **Screening Result:** _____

Comments: _____

Referral to physician for follow-up? Yes ____ No ____

I _____ certify that I have assessed the person named above
Print Name / Title
and have determined that he/she has no symptoms related to pulmonary tuberculosis.

Signature & Title _____ Date _____