Griswold HOME CARE
Tag Line

COMMUNICABLE DISEASE CLEARANCE **– CAREGIVER**

CAREGIVER NAME: _____

Consistent with the standards issued by The Centers for Disease Control, caregivers who wish to be listed on a Griswold Home Care Registry must have evidence of freedom from tuberculosis.

Caregiver Attestation: Tuberculosis (TB) History		**Circle one**	
1. Have you ever had a positive TB Skin test (or other test for TB)?	YES	NO	I DON'T KNOW
2. Have you ever had a chest x-ray to see if you have TB?	YES	NO	I DON'T KNOW
3. Have you ever had the mucus you cough up tested for TB?	YES	NO	I DON'T KNOW
4. Have you ever been told you have infectious TB?	YES	NO	I DON'T KNOW
5. Have you ever been treated with medication for infectious TB?	YES	NO	I DON'T KNOW
6. Do you live with or have you been in close contact with someone who has recently been diagnosed with TB?	YES	NO	I DON'T KNOW

I have read the information above and have answered the questions truthfully. I understand it is my responsibility to the have the results of my TB skin test(s) read within 48 – 72 hours. I understand if my skin test is not read within 72 hours, THE TEST IS NOT VALID.

Signed: _____ Date: _____

Licensed Health Care Provider:

DATE OF EXAMINATION: _____

Communicable disease status is as follows:

Tuberculosis:

- ☐ Step One Administration Date:_____ / Result Date: _____ ☐ Positive ☐ Negative
- ☐ Step Two Administration Date:_____ / Result Date: _____ ☐ Positive ☐ Negative
- ☐ BAMT administration Date:_____ / Result Date: _____ ☐ Positive ☐ Negative
- ☐ Patient has tested positive in the past
- ☐ Patient has reported possible recent exposure
- ☐ Patient shows no current signs of active disease
- ☐ X-ray completed: date _____Results:_____
- ☐ Patient completed course of treatment date_____
- ☐ Patient showed signs of active disease and is referred for treatment

Other applicable health related comments or observations, *if any*: ☐ None

_____

_____

Patient is ☐ clear **OR** ☐ *not* clear of communicable disease to provide personal care, companionship, and homemaking services including food handling to Clients who may have existing communicable disease and/or to Clients at risk of contracting communicable disease due to age or general health.

Licensed Healthcare Practitioner Signature:_____

Print name here: _____

Address _____ Telephone: _____

_____

City, State, Zip Code