Name______________________ Date___________

8 and 10 Year screening

	Yes	No	Unsure
1. Has a family member or contact had TB (Tuberculosis) or a positive TB skin test?			
2. Was your child born in a country at high risk for tuberculosis (countries other than the United States, Canada, Australia, New Zealand, or Western Europe)?			
3. Has your child traveled (had contact with resident populations) for longer than 1 week to a country at high risk for tuberculosis?			
4. Does your child have HIV/AIDS?			
5. Have your child's parents or grandparents had a stroke or heart problem before age 55?			
6. Does your child have a parent with high cholesterol (240 mg/dL or higher) or who is taking cholesterol medication?			
7. Does your child have any relatives who've experienced sudden unexplained death or early death (< age 50)?			
8. Does your child eat a strict vegetarian diet?			
9. Do you have concerns that your child does NOT eat enough iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?			
10. Do you feel you have difficulties providing enough food to feed your family			
11. Is your child ever around tobacco smoke?			

Development- Is your child doing any of the following:	**Yes**	**No**	**Unsure**
1. Having difficulty with bullies?			

2. Getting along with other children, particularly at school?			
3. Performing academically at grade level?			
4. Getting at least 10 hours of sleep a night?			
5. Getting daily exercise for at least 30 minutes?			