

Santa Clara County Tuberculosis Screening Requirement for School Entrance Effective June 1, 2014

Guidelines to Revisions to the School Mandate and Requirements

1) What are the tuberculosis (TB) screening requirements for school entrance in Santa Clara County?

Students must undergo a TB risk assessment prior to entering kindergarten or upon transfer to Santa Clara County schools. Each student must be evaluated by a primary care provider who will complete the *Santa Clara County Public Health Department TB Risk Assessment for School Entry* form.

TB risk assessment and test results (if indicated) must be submitted prior to school entry; documented TB risk assessment **up to twelve months prior to registration for school is considered valid.**

Students who have a positive risk assessment should have a TB test. All children with a positive TB test should undergo medical evaluation, including a chest x-ray. Chest x-ray is not required for children with documented prior treatment for TB disease, documented prior treatment for latent TB infection, or BCG-vaccinated children who have a positive TST and negative IGRA. The results of the chest x-ray should be included on the form. If the chest x-ray is normal and the child has no TB symptoms, they may start school. If the child has symptoms or an abnormal chest x-ray consistent with TB disease, the child must undergo further evaluation and cannot enter school unless active TB disease has been excluded or treatment has been initiated.

Please fax any forms reporting an abnormal chest x-ray to the TB Prevention and Control Program at (408) 885-2331.

2) How were the risk assessment questions chosen?

The questions on the TB Risk Assessment for School Entry form were adapted from the American Academy of Pediatrics Guidelines and the Pediatric Tuberculosis Collaborative Group recommendations and based on the epidemiology of childhood tuberculosis in Santa Clara County.

3) Who needs to satisfy the requirements of the Santa Clara County TB Mandate?

The requirement applies to the following students entering a public or private school in Santa Clara County beginning June 1, 2014 and later:

1. All students entering into kindergarten for the first time.
2. All students transferring to Santa Clara County schools into kindergarten through twelfth grade from a school outside of Santa Clara County.

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4) Who is exempt from these requirements?

1. All students who have previously met the TB screening requirements of Santa Clara County AND who have not been residing outside the county greater than 12 months; this includes students with prior completion of the Santa Clara County Public Health Department TB Risk Assessment for School Entry form for Transitional Kindergarten (TK) or other early learning program in Santa Clara County.
2. Students transferring from one school to another within Santa Clara County AND have previously met the TB screening requirements.

5) Who can enroll/register in a Santa Clara County school before TB screening requirements are complete?

A student who falls under the provisions of the McKinney-Vento Homeless Assistance Act is not required to complete TB screening before school registration and may be immediately enrolled into school. TB screening is still required for these students and should be completed in a timely manner, e.g. within 20 calendar days of enrollment. Note: School district may extend time to complete screening for up to 45 calendar days.

For students who have just returned to the U.S. from a country with an elevated TB rate, a TB blood test (IGRA) or a tuberculin skin test (TST) is recommended 8-10 weeks after their return because it can take this long to develop an immune response. Consequently, for these students, if they have no symptoms of TB disease, the IGRA or TST can be deferred until then, but must be completed within 10 weeks of return to the U.S.

6) What are acceptable TB tests?

1. Interferon Gamma Release Assay (IGRA) blood test (i.e. QuantiFERON or T-SPOT.TB), which must be done in the U.S. (recommended for BCG-vaccinated children who are at least 2 years old).
2. Mantoux Tuberculin Skin Test (TST), which must be done in the U.S. (if testing was performed at < 6 months of age it should be repeated when the child is at least 6 months old). A 4-Pronged Tine multipuncture test is not acceptable.

7) What is the definition of a positive TB test?

1. A positive TST is 10 millimeters (mm) or more of induration (swelling). Redness alone at the skin test site is not considered a positive reaction.
2. If an individual has had recent contact to a person with active infectious TB or if they are immunosuppressed they are considered to have a positive TST if there is 5 mm or more of induration.
3. A positive IGRA result interpretation is included in the laboratory report.

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8) What does a positive TB test mean?

A positive TB screening test suggests that the student has been infected with the bacteria that causes TB. Occasionally, a positive TB screening test identifies students with active infectious TB disease. It is important for students with a positive TB screening test to undergo medical evaluation to determine that there are no symptoms or signs of TB disease and that their CXR is normal. Once active TB disease has been excluded, the child should be treated for latent TB infection (LTBI). LTBI treatment is not required for school enrollment as LTBI is not contagious, but treatment is advised to prevent the child from developing TB disease in the future.

9) What is the next step for a student with a positive IGRA or positive TST result? *Note: positive means past positive or current positive result*

1. Students with a positive IGRA, positive TST, or symptoms or signs of TB disease (not required for a positive TST with negative IGRA in a BCG-vaccinated child) must submit evidence that they are free of pulmonary TB disease. This includes one of the following:
 - a. Result of chest x-ray done in the United States up to 12 months prior to school registration that shows no evidence of active pulmonary tuberculosis.
 - b. Written documentation of prior treatment for latent TB infection. See Table on p. 8.
 - c. Written documentation of ongoing treatment for latent TB infection.
 - d. Written documentation of prior treatment for active TB disease.
 - e. Written documentation of current treatment for active TB disease.
2. If the student does not have any of the above and does not have signs or symptoms of active TB (as documented by a medical provider), he/she may be conditionally enrolled, pending the results of the chest x-ray in accordance with school policy. It is recommended that conditional enrollment and admittance be extended for no more than 20 calendar days. However, school districts may extend the time before excluding the student for up to 45 days.

10) What is the next step for a student with an indeterminate IGRA test?

Students who have a positive TB risk assessment, an indeterminate IGRA result, and a negative symptom review by a primary care provider may enter school.

Note to providers: If result is indeterminate, consider repeating the IGRA or placing a TST.

11) What should schools do if a student does not have a primary care provider?

If a student does not have a source of regular care, refer to the Child Health and Disability Prevention (CHDP) program at 1 (800) 689-6669 or provide our list of community clinics.

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12) What records must students provide to meet the requirements of the TB Mandate?

1. The *Santa Clara County Public Health Department TB Risk Assessment for School Entry* form completed by a primary care provider in the U.S.
2. Students who are currently being treated or have completed treatment for TB or latent tuberculosis infection (LTBI) must provide written documentation from their health care provider. This should include medication name, dosage, date started, and date completed. This student does NOT require an additional chest x-ray.

13) What is the process for obtaining a waiver that exempts a student with a positive risk assessment from the TB test?

1. To initiate the process for an exemption for a TB test, a student who has a positive TB risk assessment must have the medical provider write a note on the Santa Clara County TB Risk Assessment for School Entry form. The provider should document that TB testing was deferred due to personal beliefs and that the child has no TB symptoms.
2. Fax this form to the TB Prevention and Control Program at (408) 885-2331.

Note: The signed back of the blue card is not acceptable for use as a waiver for the TB screening mandate in Santa Clara County.

14) Is there a process for obtaining a waiver that exempts a student from the TB Risk Assessment?

No, there is no waiver for the TB Risk Assessment.

15) If someone does not want to submit to a TB risk assessment, can they get a TB test instead?

Yes, a TB test, performed up to twelve months prior to registration for school, may be completed instead of a TB risk assessment. If the TST or IGRA is positive, the child must have a medical evaluation by a U.S. licensed primary care provider, including a chest x-ray, with documentation of these results on the risk assessment form and provided to the child's school.

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Frequently Asked Questions

Should a child who has history of BCG vaccination have a TST or IGRA?

Because Interferon Gamma Release Assays (IGRAs) have increased specificity for TB infection in children vaccinated with BCG, IGRAs are preferred over the tuberculin skin test (TST) for children ≥ 2 years of age who have a history of BCG vaccination. If an IGRA is not done, the TST results can be utilized.

Medi-Cal does not have an age restriction for IGRA reimbursement.

Are there ever indications for doing both a TST AND an IGRA?

In general, a provider should choose the appropriate test and avoid doing both tests.

If a BCG-vaccinated child has a positive TST, an IGRA can be used to help determine if this is a false-positive test due to BCG vaccination or latent TB infection.

For children who are immunocompromised, consider performing both tests AND obtain a chest x-ray. If either the TST or IGRA is positive, and TB disease has been excluded, the child should be treated for latent TB infection.

What if the student has documentation of a previous positive TST/IGRA from outside the country?

The student will be required to obtain an IGRA or TST and/or undergo a chest x-ray in the United States.

This student left the county for an extended vacation. Do they still need a TB screening test?

If the student has extended travel (e.g. > 1 month) to a country other than the U.S., Canada, Australia, New Zealand, or a country in western or northern Europe with an elevated TB rate they should be evaluated for TB infection 8-10 weeks after they return but this will not be required for school re-entry. If the child has been residing outside of Santa Clara County for >12 months, the risk assessment must be completed again.

What is considered an adequate regimen for latent TB Infection?

Recommended treatment for latent TB infection is listed in the following table. Short-course regimens (rifampin daily for four months or 12-dose weekly isoniazid/rifapentine) are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid. If a student was previously treated with 6 months of isoniazid for LTBI, this is also considered adequate treatment.

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Table. Latent Tuberculosis Infection Treatment Regimens for Children

Drug(s)	Duration	Dose	Frequency	Total Doses
Rifampin (RIF)	4 months	Children: 15-20 mg/kg Maximum dose: 600 mg	Daily	120
Isoniazid (INH) and Rifapentine (RPT)	3 months	<ul style="list-style-type: none"> • Isoniazid 2-11 years old: 25 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg) ≥ 12 years old: 15 mg/kg rounded up to nearest 50 or 100 mg (max. 900 mg) • Rifapentine 10.0-14.0 kg: 300 mg 14.1-25.0 kg: 450 mg 25.1-32.0 kg: 600 mg 32.1-50.0 kg: 750 mg >50 kg: 900 mg • Vitamin B6 50 mg weekly 	Once weekly	12
Isoniazid (INH)	9 months	10 mg/kg (range, 10-15 mg/kg) Maximum dose: 300 mg Recommended pyridoxine dosage: 25 mg for school-aged children (or 1-2 mg/kg/day)	Daily	270

*Short-course regimens (rifampin daily for four months or 12-dose weekly isoniazid/rifapentine) are preferred (except in persons for whom there is a contraindication, such as a drug interaction or contact to a person with drug-resistant TB) due to similar efficacy and higher treatment completion rates as compared with 9 months of daily isoniazid.

**Rifampin (RIF) is formulated as 150 mg and 300 mg capsules. Rifapentine (RPT) is formulated as 150 mg tablets in blister packs that should be kept sealed until usage. Isoniazid (INH) is formulated as 100 mg and 300 mg tablets.

For additional information: www.sccphd.org/tb.

County of Santa Clara Public Health Department TB Prevention & Control Program: (408) 792-1317.

References

American Academy of Pediatrics. Tuberculosis. In Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. Red Book: 2018 Report of the Committee on Infectious Diseases. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018: 829-853.

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