



## NORTHWOOD SCHOOL HEALTH SERVICES

**THE ENCLOSED FORMS ARE REQUIRED FOR ADMISSION AND ARE DUE BY JULY 15, 2011.**

**All forms must be completed and written in English.**

The enclosed health forms are designed to assist the Health Office staff in providing optimal health care to your child while at Northwood School. Children learn best when they are healthy. We are committed in helping them stay healthy and provide comfort to them when they are ill.

Physical Exam: *Must be performed after May 1, yearly.* Please note the forms that must be signed by both the physician and parent. There are eight forms requiring signatures.

If you have any questions or concerns please feel free to leave a message for either Ingrid or Karen and we will call you back. We can be reached at 518-523-3357, ext. 217.

Have a great summer and we will see you in September.

Sincerely,

Karen Fleming, R.N.      Ingrid Van Slyke, R.N.

## INSURANCE INFORMATION

All Northwood students must be covered by a comprehensive medical health insurance plan. Please contact your insurance company to discuss benefits, deductibles, co-payments and out of network coverage. Any student may purchase the school insurance as needed.

**INTERNATIONAL STUDENTS** – All students residing outside of North America **must** purchase our school insurance policy.

**SCHOOL PHYSICIAN** – Dr. Michael Pond. He and his associates work at Mountain Medical Urgent Care in Lake Placid. Their phone number is 518-523-7575. We also use the Adirondack Medical Centers in Lake Placid and Saranac Lake for medical needs like out-patient physical therapy, emergency room, hospital and health center.

**PRESCRIPTIONS** – Filled at Kinney’s Pharmacy at 106 Saranac Avenue, Lake Placid. Their phone number is 518-523-2011, Fax 518-523-1933. If you have a prescription plan, please call pharmacist Dick Cummings and give him your insurance information. **You will be charged the full prescription price if you do not do this.**

**INSURANCE CARDS** – Please provide front and back copies of insurance cards – Medical and Prescription. Sample as follows:



**DISCLOSURE OF INFORMATION**

I authorize the Northwood School Health Services staff to share all health information pertinent to my child's health or school progress with school personnel and/or other health care providers to which my child may be referred.

The reasons for the disclosure are: Patient Care and Safety and/or Medical Review.

This authorization is to remain in effect until revoked in writing by the undersigned parent/guardian.

I consent to Northwood's release of the above information. I understand that use of this information for any reasons other than the reasons stated above is prohibited and that disclosure of this information to other parties for an unauthorized reason is prohibited.

This consent is subject to revocation at any time.

I executed this form as: *(please check one)*    \_\_\_ Legal Guardian    \_\_\_ Parent

of \_\_\_\_\_  
(name of student)

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

Return form to the attention of:

Karen C. Fleming, R.N. & Ingrid VanSlyke, RN  
Northwood School  
School Health Services  
P.O. Box 1070  
Lake Placid, NY 12946

# ***NORTHWOOD SCHOOL STUDENT EMERGENCY INFORMATION***

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Gender \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's name \_\_\_\_\_

Primary Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Student Social Security # \_\_\_\_\_ Home Phone Number \_\_\_\_\_

**Parent/Guardian Name** \_\_\_\_\_ **Parent/Guardian Name** \_\_\_\_\_

Relationship to Student \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Mailing Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

\_\_\_\_\_

E-mail Address \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Person to be contacted in an emergency if parent can not be reached:** \_\_\_\_\_ **Relationship** \_\_\_\_\_

Home phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Health Insurance Company** \_\_\_\_\_ **Company Telephone Number** \_\_\_\_\_

Name of Policy Subscriber \_\_\_\_\_ Subscriber's date of birth \_\_\_\_\_

**Policy ID Number** \_\_\_\_\_ **Group Number** \_\_\_\_\_

**Please attach copies (Front & Back) of the medical and prescription insurance cards. As well as pharmacy plan ID #.**

## ***MEDICAL SUMMARY FOR EMERGENCY CARE***

**Special Health Concerns:** \_\_\_\_\_

**Medication, Insect or Food Allergies:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Date of last tetanus immunization:** \_\_\_\_\_

**History of concussion or loss of consciousness with dates of occurrence:** \_\_\_\_\_

### **MEDICAL AUTHORIZATION**

**I give permission for:**

1. The Northwood School Nurse and Athletic Trainer to provide routine medical care for minor illnesses and injuries as appropriate, and to take student to Adirondack Medical Center, ER, Lake Placid Sports Medicine, Mountain Medical Urgent Care Services, or other providers if evaluation is needed.
2. A licensed physician to provide emergency medical care in the event my child is seriously ill or Injured. Northwood School will make every reasonable effort to contact the responsible parent or guardian in a timely manner if emergency treatment is needed.

Date \_\_\_\_\_ Signature of Parent or Guardian \_\_\_\_\_

# **NORTHWOOD SCHOOL HEALTH RECORD- Part 1**

**Student Name:** \_\_\_\_\_

*Northwood School Medical History to be filled out by parent and student and reviewed by healthcare provider at time of physical exam.*

## **MENTAL HEALTH HISTORY**

*For every "yes" below for which treatment has been received, please sign an Authorization to Release Records form for each healthcare provider.*

- |  |            |
|--|------------|
| 1. Is he/she currently experiencing emotional or behavioral difficulty?                                  | No__ Yes__ |
| 2. Recent weight loss or gain  | No__ Yes__ |
| 3. Eating disorder   | No__ Yes__ |
| 4. Insomnia  | No__ Yes__ |
| 5. Depression  | No__ Yes__ |
| 6. Anxiety   | No__ Yes__ |
| 7. Suicidal gestures   | No__ Yes__ |
| 8. Cutting or other self-injury  | No__ Yes__ |
| 9. History of emotional, physical or sexual abuse?   | No__ Yes__ |
| 10. ADD/ADHD or other learning disorder  | No__ Yes__ |
| 11. Is he/she currently receiving counseling or has he/she received counseling<br>In the past 12 months? | No__ Yes__ |

**If yes, please provide a letter from therapist/mental health caregiver detailing diagnosis and current treatment plan.**

- |  |            |
|--|------------|
| 12. Has he/she ever been in a residential treatment program? | No__ Yes__ |
| 13. Does he/she currently use alcohol or tobacco products?   | No__ Yes__ |
| 14. Does he/she have a history of substance abuse?           | No__ Yes__ |

If response of "yes" to any of the above, please explain:

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### **History**

- |   |            |   |            |
|---|------------|---|------------|
| 1. Anemia, bleeding disorder  | No__ Yes__ | 12. Diabetes                                  | No__ Yes__ |
| 2. Cancer, Leukemia   | No__ Yes__ | 13. Epilepsy, seizures                        | No__ Yes__ |
| 3. Heart Murmur, congenital defect                                      | No__ Yes__ | 14. Eye conditions                            | No__ Yes__ |
| 4. High/low blood pressure, fainting<br>Dizziness                       | No__ Yes__ | 15. Recurring ear infections,<br>hearing loss | No__ Yes__ |
| 5. Chest pain, palpitations   | No__ Yes__ | 16. Headache, migraine                        | No__ Yes__ |
| 6. Thyroid Disease  | No__ Yes__ | 17. Frequent strep throat                     | No__ Yes__ |
| 7. Abdominal pain, ulcer  | No__ Yes__ | 18. Urinary tract infection                   | No__ Yes__ |
| 8. Recurring vomiting, diarrhea,<br>Constipation, Colitis, IBS, Crohn's | No__ Yes__ | 19. Motion sickness                           | No__ Yes__ |
| 9. Orthopedic problems  | No__ Yes__ | 20. Menstrual problems                        | No__ Yes__ |
| 10. Concussion/s  | No__ Yes__ | 21. Special Diet                              | No__ Yes__ |
| 11. Mono, Epstein Barr  | No__ Yes__ | 22. Asthma, Exercised<br>Induced or Chronic   | No__ Yes__ |

If response of "yes" to any of the above, please explain:

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# NORTHWOOD SCHOOL HEALTH RECORD- Part 2

**518-523-3357, ext. 217 – 518-523-3405 fax**

**To the Physician: Please review the student's history and complete the medical examination form.**  
(This form may not be completed by a member of student's immediate family.)

**Student Name** \_\_\_\_\_ **Date of Exam** \_\_\_\_\_ **Birthdate** \_\_\_\_\_

**Physical Examination**

Body Mass Index (BMI) \_\_\_\_\_ Weight Status Category (BMI Percentile) \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ BP \_\_\_\_\_  
Vision: R 20/\_\_\_\_ L 20/\_\_\_\_ Corrected: Y N Pupils: Equal \_\_\_\_\_ unequal \_\_\_\_\_  
Hearing: R \_\_\_\_\_ L \_\_\_\_\_ Contacts \_\_\_\_\_ Glasses \_\_\_\_\_

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

	No	Yes	If yes, describe
Head, ears, nose, throat			
Hearing			
Respiratory			
Cardiovascular			
Gastrointestinal			
Neurological			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/endocrine			
Neuropsychiatric			
Skin			
Allergies			
Any other condition			

**CHRONIC DISEASE ASSESSMENT:**

Yes No  
\_\_\_\_ Asthma Mild \_\_\_\_ Severe \_\_\_\_  
\_\_\_\_ Diabetes Type I \_\_\_\_ Type II \_\_\_\_  
\_\_\_\_ Anaphylactic Reaction To: \_\_\_\_\_  
\_\_\_\_ Seizure Disorder: Type \_\_\_\_\_  
\_\_\_\_ Cardiac Condition \_\_\_\_\_  
\_\_\_\_ Other (Please specify) \_\_\_\_\_

**MEDICATIONS** currently being take (including herbal supplements) \_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

Type of reaction (rash, urticaria, anaphylaxis) \_\_\_\_\_

**SPORTS RESTRICTIONS** (ability to participate in sports) \_\_\_\_\_

I have reviewed this student's medical and family history, immunization status and have performed a physical examination:  
\_\_\_\_ I believe this student is able to participate in full contact/non-contact sports without restrictions  
\_\_\_\_ Student should be restricted from the following activities: \_\_\_\_\_

**PRINT:** Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_ Fax # \_\_\_\_\_  
\_\_\_\_\_

Examiner's Signature \_\_\_\_\_ Date \_\_\_\_\_

## **NORTHWOOD SCHOOL IMMUNIZATIONS RECORD**

Name \_\_\_\_\_

Date \_\_\_\_\_

A completed immunization record is required for school entry. Please attach a photocopy of records or have your healthcare provider list immunizations and dates administered. We follow N.Y.S. Dept. of Health/ Immunization Program.

\*Last tetanus needs to be within 10 years. A new vaccine Tdap is recommended which contains pertussis protection. (We have seen a reoccurrence of pertussis in the Northeast in the past few years.) \*EVERY NEW

**STUDENT NEEDS TO HAVE A TUBERCULIN TEST DONE BEFORE COMING TO SCHOOL THIS FALL.**

\*Each student must also have received 2 doses of MMR or the equivalent.

\*Every student must receive the 2 dose or 3 dose Hepatitis B series or be in process with follow-up dates arranged to complete the series. I will need written permission from you to complete the series while in school. (Two (2) dose series only acceptable for 11-15 year olds.)

\*VARICELLA: Evidence of serologic antibodies or documentation by physician of disease is necessary. If student has not had chicken pox yet it is recommended they receive the varicella vaccine (2 injections, 4 weeks apart.)

\*A diagnosis by physician of a student having measles, mumps, or varicella is acceptable proof of immunity to those diseases. The physician needs to provide written documentation.

\*Demonstrated serologic evidence of Measles, Mumps, Rubella, Hepatitis B. or Varicella is acceptable proof of immunity to these diseases. Please send copies of blood work results.

\* Meningococcal Vaccine is strongly recommended for boarding students. Please speak with your physician about it.

### **Required Immunizations written in English**

Vaccine	1	2	3
<b>Diphtheria Vaccine, DTaP or DTP</b> 3 doses required	1	2	3
<b>Tdap</b> 1 dose required	1		
<b>Polio OPV/IPV</b> 3 doses required	1	2	3
<b>Hepatitis B</b> 3 doses required	1	2	3
<b>Meningococcal-Required</b>	1		
<b>MMR</b> 3 doses - required	1	2	3
<b>Chicken Pox</b> 2 doses or disease	1	2	
<b>HPV</b> 3 doses – not required	1	2	3

**Mandatory for all new students:** Tuberculin skin test:

Date: \_\_\_\_\_ Type: \_\_\_\_\_ Induration \_\_\_\_\_ mm

Result: Negative \_\_\_\_\_ Positive: \_\_\_\_\_

**If positive, report of chest X-ray:** BCG \_\_\_\_\_ yes/no

**This form must be received by the Health Center by July 15, 2011.** Students must be compliant with New York State Department of Health and Northwood School immunization requirements. Students **will not** be permitted to participate in sports and/or attend classes if compliance requirements are not met. If applicable, documentation of religious exemption from vaccinations is required.

**The above immunizations have been reviewed by a licensed health care provide.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

## NORTHWOOD SCHOOL STANDING ORDERS –2011-2012

The Health Office and faculty provide the students with over-the-counter medication from The Northwood School Standing Orders signed by your physician. NY State does not allow RN's to give out medication, prescribed or over-the-counter without a physician's order. The standing orders allow the faculty to assist your self-directed child if he/she requests Ibuprofen, Tylenol, Sudafed, throat lozenges, etc. If you have a particular medication that you would like your child to take, you need to get a physician's order. **No over the counter medications are allowed in rooms.**

**International Students: DO NOT SEND INTERNATIONAL BRAND MEDICATIONS.**

**ABREVA** – Apply as directed per package insert.

**BONINE (ANTIVERT)** – 25 mg PO Bid prn for motion sickness

**BENADRYL** – 25-50 mg PO Q 4 hours prn for hives & allergic reactions

**EPI PEN** – For acute allergic reaction – use as directed and send to ER

**ZYRTEC** – 10 mg PO daily prn for seasonal allergic rhinitis

**SUDAFED** – 60 mg PO Q 6 hours prn nasal and/or Eustachian congestion

**ROBITUSSIN DM** – 2 Tsp. PO Q 4 hours prn cough and chest congestion

**MENTHOL COUGH DROPS** – PRN for cough

**TUMS/ROLAIDS** – 2 TABLETS Q 6 hours PRN acid indigestion or heartburn

**MAALOX OR MYLANTA** – 2 Tbs PO Q 4 hours prn for heartburn or gastritis

**TYLENOL** – 325 MG tablets – 2 tabs PO Q 4 hours prn for headache, pain, T 101

**IBUPROFEN** – (Motrin or Advil) – 400 mg PO Q 4-6 hours prn headache, menstrual cramps, muscular discomfort, T 101- Give with food. Post sports related muscle injuries or sprains – 600 mg-800 mg 2-3 times daily prn. Give with food.

**CORTISONE CREAM 1%** - Apply to affected area 2-3 times a day prn. To rash, insect bites, skin inflammation, eczema.

Follow up with MD if no improvement or recurrent.

**LOTRIMIN CREAM** – Apply to affected area twice a day prn for athlete's foot or groin area. Follow up with MD if no improvement or recurrent.

**BACITRACIN OR TRIPLE ANTIBIOTIC OINTMENT** – Apply to topical infection or abrasions as needed prn

**NIX** – Per package instructions for lice or scabies prn

**LUBRICATING TEAR DROPS** – For dry eyes prn

**CEPACIL/CHLORASEPTIC LOZENGES** – Prn for sore throats – Follow up with MD if no improvement

**SENOKOT**- 2 tabs PO Q Day prn constipation. May use up to 3 days then follow- up with MD.if no improvement

**BENEFIBER/METAMUCIL** – Fiber. As directed prn

**VITAMIN C** – 500 mg PO daily prn

**EMERGEN-C or AIRBORNE** – per package instruction

### **\*MEDICATION POLICY – Review with your child**

Please keep in mind that no one can force your teenager to take a medication. You will be notified if your child frequently misses medication appointments at the nurse's office.

- ALL medications must be reviewed by nurse, who determines how and where the medication is to be kept and administered. These are to be turned in on opening day.
- ALL medications are to be delivered directly to the nurse or to a dorm parent.
- It is the parent's responsibility to keep enough medication at home for school breaks. Please avoid sending medications with students in transit.
- Parents or guardians assume responsibility for refills and pharmacy charges.
- It is the student's responsibility to go to the nurse's office to take or refuse a prescribed medication.
- It is the student's responsibility to go to the dorm-parent for evening or weekend doses.
- Medications left behind at the end of the year will be destroyed, i.e. not mailed.

NAME OF STUDENT \_\_\_\_\_

PARENT OR GUARDIAN SIGNATURE \_\_\_\_\_

STUDENT SIGNATURE \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_

**PHYSICIAN ORDER FOR PRESCRIBED MEDICATIONS**

**Any medication your child will be taking on a regular basis that is a prescription medicine must be accounted for below. Please photocopy this page for any additional prescription medicines. Any antibiotics they are on for acne or inhalers must also be listed below. If you have a particular over the counter med that is not on the NWS standing orders or herbal supplement that they will be taking please have the physician order below. Please review medication policy page 8.**

Doctor, please complete and sign the following medication order(s) for any medications that the indicated student will be taking during the school year at Northwood School. Please send updated copies with any dose or medication change.

STUDENT: \_\_\_\_\_  
D.O.B.: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_  
PRESCRIBING PHYSICIAN (please print name here): \_\_\_\_\_

Medication & Dose _____
Route _____ Frequency _____
Diagnosis medication is prescribed for: _____
Remarks: _____
Signature: _____ Date: _____

Medication & Dose _____
Route _____ Frequency _____
Diagnosis medication is prescribed for: _____
Remarks: _____
Signature: _____ Date: _____

Medication & Dose _____
Route _____ Frequency _____
Diagnosis medication is prescribed for: _____
Remarks: _____
Signature: _____ Date: _____

Medication & Dose _____
Route _____ Frequency _____
Diagnosis medication is prescribed for: _____
Remarks: _____
Signature: _____ Date: _____

Please feel free to contact Northwood School Health Services with any questions or concerns.  
Northwood School – PO Box 1070 Lake Placid, NY 12946  
518-523-3357 ext. 217 518-523-3405 fax

## MENINGITIS INFORMATION

Dear Parent:

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a new law in New York State. On July 22, 2003, Governor Pataki signed New York State Public Health Law (NYS PHL)~2167 requiring residential schools to distribute information about meningococcal disease and vaccination to all students in grades 7-12. This law became effective on August 15, 2003.

Northwood School is required to maintain a record of the following for each student:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the student's parent or guardian (or the student if he/she is 18 years of age or older; AND
- Information on the availability and cost of meningococcal meningitis vaccines (Menomune); and (Menactra)
- A record of meningococcal meningitis immunization within the past 10 years;  
OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization signed by the student's parent or guardian (or the student if he/she is 18 years of age or older).

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

We received this mandate on August 15, 2003. Please talk with your physician about this vaccine for your child. If you choose to have your physician administer the vaccine, have him/her sign the enclosed paper with the date given and their name.

I have spoken with the Essex County Public Health nurses, and they will come to campus to administer the Menactra vaccine if they have your signed permission as noted in #2. The charge is approximately \$100.00 and will be billed to your account at Northwood School. There is no third party payment, so it would be best for you to have your child immunized with your own health care provider before September 1st.

If you choose to have the Menactra vaccine administered while at Northwood School, please make sure the form is filled out completely and returned to me before September 1, so we can make arrangements with the ECPH nurses. By signing the Vaccination Response Form you are authorizing Northwood School to bill the \$100.00 fee to your account if the vaccine is given at Northwood. Enclosed is an information sheet on Meningococcal Disease that may answer some of your questions.

**Regardless of your decision, the Vaccination Response Form must be returned by July 15, 2011. THIS IS THE LAW IN NEW YORK STATE.**

Thank you for your cooperation in this matter.  
Sincerely,

Karen C. Fleming, R.N. & Ingrid Van Slyke, R.N.  
School Nurses

## VACCINATION RESPONSE FORM

**New York State Public Health Law** requires that all parents or guardians of residential school students (or residential students 18 years of age and older) in grades 7-12, complete and return the following form to Northwood School Health Office.

**Check one box and sign below.**

My child (for students over the age of 18: I have):

had the meningococcal meningitis immunization (Menomune <sup>TM</sup>) within the past 10 years. Date received: \_\_\_\_\_

(Note: The vaccine's protection lasts for approximately 3-5 years. Revaccination may be considered within 3-5 years.)

has received Menactra vaccine this year.

read, or have had explained to me, the information regarding meningococcal meningitis disease. My child (I) will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider or arranged by Northwood School Health Office.

read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that my child (I) will **not** obtain immunization against meningococcal meningitis disease.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Parent/Guardian if student is a minor)

Print Student's Name \_\_\_\_\_ Student's Date of Birth \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Student Cell Phone # \_\_\_\_\_

Mailing Address \_\_\_\_\_

Phone Number \_\_\_\_\_

## TUBERCULIN SKIN TEST POLICY

Tuberculosis (TB) is an infection caused by the bacteria *Mycobacterium tuberculosis*. It can occur in children and adolescents. TB is spread from person-to-person and can have serious life-threatening consequences if untreated. It is more common in certain areas of the world – including Asia, the Middle East, Africa, Latin America, and Eastern Europe.

It is the policy of Northwood School that every new student must have a tuberculin skin test (TST) performed no more than six (6) months prior to commencement of their first school year at Northwood. The purpose of this test is to determine if the child has TB. This policy applies to all children, regardless of whether or not they have received the BCG vaccine (a vaccine which provides some protection against tuberculosis).

If a TST has not been performed prior to arrival at Northwood School, we will arrange for one to be done upon arrival. Administration and interpretation of tuberculin skin testing will be performed in accordance with the recommendations put forth by the Centers for Disease Control (CDC) and the American Academy of Pediatrics Committee on Infectious Diseases.

In Summary:

- A small amount of solution will be injected beneath the skin of the forearm.
- The area of injection will be assessed in 48-72 hours by a health care professional
- Results of the TST are recorded as millimeters of induration (hardness). A reaction to the TST of  $\geq 15$  mm of induration is considered positive in any child. A reaction of  $\geq 10$  mm of induration is considered positive in children born in high-prevalence regions of the world.
- Interpretation of TST results in BCG recipients is the same as for people who have not received BCG vaccine. As per CDC guidelines, a positive TST result in a child who may have received the BCG vaccine should not be attributed to the BCG vaccine.
- Children with a negative TST require no further evaluation or treatment.
- All children who have a positive TST result are required to have a radiographic evaluation for the presence of active tuberculosis (2-view chest x-ray).
- In asymptomatic children who have a positive TST but normal chest x-ray, it is possible that they have been exposed to tuberculosis in the past and currently have latent tuberculosis infection. In these cases, **it is recommended that they be given 9 months of once-daily medication (isoniazid) to prevent the development of active tuberculosis disease.** Among children, efficacy of isoniazid in protecting them from later development of active tuberculosis approaches 100%.
- In children with a positive TST and an abnormal chest x-ray, it is recommended that 9 months of a multi-drug regimen.