Reporting exposure

Should an exposure incident occur contact the school nurse immediately. Each exposure must be documented by the employee on an "Accident Report Form" (see Appendix D). The school nurse will add any additional information as needed.

An immediately available confidential medical evaluation and follow-up will be conducted by a physician. The following elements will be performed:

- Document the routes of exposure and how exposure occurred.
- Identify and document the source individual (see Appendix E), unless the employer can establish that identification is infeasible or prohibited by Federal, State or local law.
- Attempt to obtain consent and test source individual's blood as soon as possible to determine HIV, HBV, and HCV infectivity and document the source's blood test results.
- If the source individual is known to be infected with either HIV, HBV or HCV, testing need not be repeated to determine the known infectivity.
- If permitted by law or if consent is given, provide the exposed employee with the source individual's test results and information about applicable disclosure laws and regulations concerning the source identity and infectious status.
- After obtaining consent, collect exposed employee's blood as soon as feasible after the exposure incident and test blood for HBV, HIV, and HCV serological status.
- If the employee does not give consent for HIV, HBV and HCV serological testing during the collection of blood for baseline testing, preserve the baseline blood sample for at least 90 days.

Appendix D *Exposure Incident Report* Form and Appendix E *Request for Source Individual Evaluation* and Appendix F *Employee Exposure Follow-Up Record (Medical Response Form)* will be provided to the employee so they may bring them along with any additional relevant medical information to the medical evaluation. Original copies of these appendixes will be maintained with the employee's medical records.

A physician will review the circumstances of the exposure incident to determine if procedures, protocols, and/or training need to be revised.

EXPOSURE INCIDENT REPORT

Name: _____ Age: _____ DOB:_____

Street: _____

City: _____ State: _____ Zip Code: _____

Telephone Number: _____ Home School District: _____

Program & School Attending: _____ Teacher: _____

Mother's Name: _____ Day Phone: _____
(Last) (First)

Father's Name: _____ Day Phone: _____
(Last) (First)

Legal Guardian: _____

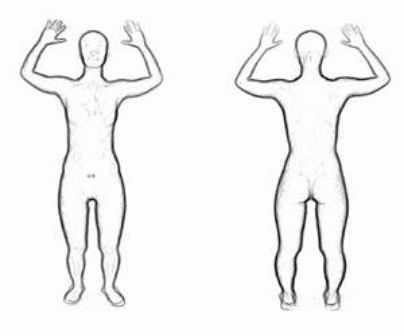
Doctor's Name: _____ Date of Accident: _____

Time & Place of Accident: _____

Allergies (if any): _____

Medication(s) Taken: _____ When: _____

Front Back



Description of Injury/Illness:

First Aid Provided:

Person(s) Administering First Aid: _____

Ambulance called at: _____ AM PM By Whom: _____ (initials)

Arrived at: _____

Parents notified at: _____ By Whom: _____ (initials)

Arrived at: _____

Patient referred to: _____ (Doctor, Parent, Ambulance, Hospital, etc.)

Follow up after trauma:
Completed by: _____ Date: _____

REQUEST FOR INFECTION CONTROL EVALUATION FOR POSSIBLE BLOODBORNE PATHODGEN EXPOSURE (SOURCE INDIVIDUAL EVALUATION)

Dear (Emergency Room Medical Director, Infection Control Practitioner):

During a recent transport of a patient to your facility, one of our prehospital care providers was involved in an event which may have resulted in exposure to a bloodborne pathogen.

I am asking you to perform an evaluation of the source individual who was transported to your facility. Given the circumstances surrounding this event, please determine whether our prehospital care worker is at risk for infection and/or requires medical follow-up.

Attached is a "Request for Infection Control Evaluation of Possible Bloodborne Pathogen Exposure (Documentation and Identification of Source Individual)" form which was initiated by the exposed worker. Please complete the source individual section and communicate the findings to the designated medical provider.

The evaluation form has been developed to provide confidentiality assurances for the patient and the exposed worker concerning the nature of the exposure. Any communication regarding the findings is to be handled at the medical provider level.

We understand that information relative to human immunodeficiency virus (HIV) and AIDS has specific protections under the law and cannot be disclosed or released without the written consent of the patient. It is further understood that disclosure obligates persons who receive such information to hold it confidential.

Thank you for your assistance in this very important matter.

Sincerely,

ADAPTED FROM: ***A Prehospital Care Provider's Guide to Aids***
New York State Department of Health, January 1990

To be completed by health care provider

Confidential

MEDICAL RESPONSE FORM
Request for infection Control Evaluation of Possible
Bloodborne Pathogen Exposure of a Prehospital Case Worker
(Documentation and Identification of Source Individual)

Name of Exposed Employee (Prehospital case worker):

Exposed Employee's Phone Number:

Name and Phone Number of Medical Provider Who Should be Contacted:

INCIDENT INFORMATION

Date:

Name or Medical Record Number of the Individual Who is the Source of the Exposure:

NATURE OF THE INCIDENT

Contaminated Needle stick Injury:

Blood or Body Fluid Splash Onto Mucous Membrane or Non-Intact Skin:

Other:

REPORT OF SOURCE INDIVIDUAL EVALUATION

Chart Review by: Date:

Source Individual Unknown – Researched By Date:

TESTING OF SOURCE INDIVIDUAL'S BLOOD

CONSENT – Check One: Obtained: Refused:

Identification of source individual infeasible or prohibited by state or local law. State why if infeasible:

CHECK ONE:

Evaluation of the source individual reflected no known exposure to Bloodborne Pathogen:

Evaluation of the source individual reflected possible exposure to Bloodborne Pathogen and medical follow-up is recommended:

NOTE: Report of the results of the source individual's blood tests to the medical provider named above who will inform the exposed employee. Do not report blood test findings to the employer.

NOTE: ***HIV-related information cannot be released without the written consent of the source individual***

Person Completing Report: **Date:**

Employee Refused Medical Evaluation (if applicable): **Employee Signature**: **Date:**

Confidential

EMPLOYEE EXPOSURE FOLLOW-UP RECORD

Employee's Name:	Job Title:
Occurrence Date:	Reported Date:
Occurrence Time:	

SOURCE INDIVIDUAL FOLLOW-UP	
Request Made To:	
Date:	Time:

EMPLOYEE FOLLOW-UP
Employee's Health File Reviewed By:
Date:

Referred to healthcare professional with required information:	
Name of Healthcare Professional:	
By Whom:	Date:

Blood Sampling/Testing Offered:	
By Whom:	Date:

Vaccination Offered/Recommended:	
By Whom:	Date:
ISG:	Hepatitis B Immune Globulin:
Hepatitis B Vaccine:	Diphtheria/Tetanus:
Other:	

Counseling Offered:	
By Whom:	Date:

Employee advised of need for further evaluation of medical condition:	
By Whom:	Date: