Bloodborne Pathogen Exposure Procedures

Once and employee has direct contact with blood or other body fluids, such as from a needle stick, cut, bite, or eye splash, documentation must be completed.

- **Complete Exposure Incident Report Form and return to Human Resources**

If a student was involved in the incident, you must:

- **Complete Exposure Notice and send it to the parent/guardian of student involved**
- **Send Authorization to release information to parent/guardian of student involved**

Exposure Incident Report Form

Employee's Name: _____ Employee ID #: _____

Employee's Work Location: _____

Exposure incident date and time:

_____

Please describe in detail what happened:

_____

_____

_____

_____

Who was the source of the blood or other body fluid (Please print name, address, and phone number)

_____

_____

_____

If the source was a child, the building/department administrator must immediately notify the parent/guardian of the incident.

Date of notification: _____

Did the parent/guardian consent to have the child tested? YES ☐ NO ☐

Date the Authorization to Release Information and Exposure Notice were sent _____

Please note: If the parent/guardian consented to have the child tested, the results are confidential and can only be shared with the medical clinic for treatment of the employee.

Signature _____ Date _____

Return form to Human Resources Benefits Office
fax: 425-385-4135
email: benefits@everettsd.org

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EVERETT PUBLIC SCHOOLS®

Parent/Guardian Copy

Exposure Notice

Student's Name: _____ Date: _____

It is possible that another person has been exposed to the above-named student's blood and/or other bodily fluids. Several viruses can be transmitted by such exposure including the following:

- Hepatitis B antigen
- Hepatitis C antibody
- Human Immunodeficiency Virus (HIV) antibody

There is potentially an increased risk to the exposed person for any of the viruses listed above. While it is not required, we ask that the student named above be tested.

The results are handled with strict confidentiality and used by the physician to determine treatment, if necessary, of the exposed individual. Information obtained by the testing of the student will not be communicated with any employee of the district. *Actual test results will be released only to you.* To make arrangements for testing, please contact Concentra at 425.259.0300.

If you choose to use a medical office or clinic for testing other than Concentra, please use the authorization to release information for enclosed. Should you have any questions or concerns regarding this process please contact Benefits in Human Resources at 425.385-4115.

Thank you for your assistance.

EVERETT PUBLIC SCHOOLS®

Parent/Guardian Copy

Authorization to Release Information

I, _____ Date of Birth: _____
hereby authorize _____
to release information contained in medical records of _____
Send records to: Concentra, 3726 Broadway Suite 101, Everett, WA 98201

This information may include records of treatment for drug or alcohol dependence, psychiatric illness or sexually transmitted diseases including AIDS and testing for AIDS unless you specifically prohibit its release.

Information to be disclosed (*check appropriate box(es)*):

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Operative Report
- ☐ Pathology Reports
- ☐ Consultations
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ EKG's
- ☐ Other

Specify date(s) of treatment: _____
Purpose for which the disclosure is made: _____

I hereby release from all legal responsibility or liability for the release of the above-mentioned information. I understand that my records are protected under the federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I have the right to withdraw this authorization at any time, except for action already taken, and that such revocation must be in writing. Further I understand that this authorization, without prior revocation, will automatically expire 90 days from the date of my signature.

I DO NOT consent to the release of the following record information (*check appropriate box(es)*):

- ☐ Sexually Transmitted Disease
- ☐ HIV Testing Results
- ☐ Substance Abuse – Alcohol or Drug
- ☐ Mental Health

DO NOT SIGN BEFORE READING (*Patient or person giving consent if not patient*)
Date: _____ Signature: _____
Date: _____ Witness: _____

NOTICE TO PERSONS/ORGANIZATIONS WHO RECEIVE MEDICAL INFORMATION: REDISCLOSURE PROHIBITED: It is an expectation that you will recognize that the information disclosed to you is private information and that redisclosure without additional patient consent (unless required by law) is prohibited.

CAUTION: Legal counsel advises that the release of information authorized herein may result in the waiver of the patient of certain legal rights, including the protection of the physician/patient privilege, and rights under the federal alcohol and drug laws related to treatment and Washington laws relating to mental illness, or about tests for treatment of sexually transmitted disease, such as HIV (AIDS). If you have any questions above waiving these rights, you are advised to consult your attorney.

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