

BLOOD AND/OR BODY FLUID EXPOSURE**GUIDELINES TO DETERMINE BLOOD OR BODY FLUID EXPOSURE**

_____ Yes	_____ No	Did the blood or body fluid visibly containing blood contact the individual's mucous membrane?
_____ Yes	_____ No	Did the blood or body fluid visibly containing blood come into contact with the individual's broken skin (less than 24 hours old) including cuts or open skin rashes or breaking of skin in bite?
_____ Yes	_____ No	Did the blood or body fluid visibly containing blood penetrate the individual's skin by a contaminated needle, lancet, glass or teeth?
_____ Yes	_____ No	Did the bite break the individual's skin and cause bleeding.

If you answered yes to any of the above questions, you have had an exposure. If the blood or body fluid contact does not meet any of the exposure criteria listed above, the incident is not an exposure that could transmit disease.

- A. **NOTIFY** administrator/supervisor immediately. Contact any one of the school nurses on duty immediately. **MAINTAIN CONFIDENTIALITY OF PERSONS INVOLVED.**
- B. Administer first aid based on the type of exposure:
 1. Puncture/laceration (bites and scratches): flush with soapy water, scrub and encourage bleeding.
 2. Ocular exposure (eye): flush with clean water for 20 minutes.
 3. Mucous membrane (mouth): flush with hydrogen peroxide (half strength with water) for 30 seconds. Repeat several times. **DO NOT SWALLOW.**
- C. **Employees:** Complete Employee Information Form, Worker's Compensation Form "First Report of Injury" and call Human Resources office at 231-8513 to report injury. Make copies of these forms to send with employee.
- D. **Students:** Complete Student Accident Report form. Call parent/guardian and refer to the Urgent Care Department at APMC.
- E. **Source Person:** Complete Source Person Information Form. Parent or legal guardian must be contacted and asked to take the source person to the Urgent Care Department at APMC on the day of the exposure. If parent/guardian refuses to go to the Urgent Care Department at APMC have them sign declination statement on bottom of form.
- F. Individuals involved in exposure are asked to go to the Urgent Care Department, Affiliated Medical Center; 101 Willmar Avenue SW; Willmar, MN 56201. Phone (320) 214-6922 on the day of the exposure. Send a copy of the appropriate form with the individual. Call the Urgent Care Department to inform them of the incident. They will get the necessary consent forms for testing.
- G. All employee and student exposures that occur between the hours of 8:00 a.m. and 5:00 p.m. should be referred to the Urgent Care Department. The Urgent Care Department staff will review the incident, immunization status and get consent for blood testing. The Urgent Care Department then determines risk and treatment. The individuals involved will receive a letter from the Urgent Care Department. Urgent Care coordinates the billing of staff exposures to the school district and student to student exposures to the student's health insurance. It does not matter if the student or employee has a different clinic they usually go to, they need to go to the Urgent Care Department. They are able to bill all insurance providers. Their own clinic/physician will be notified of results/recommendations if the individual requests.

EMPLOYEE BLOOD EXPOSURE INCIDENT REPORT

Name: _____ Birthdate: _____
 Address: _____ City: _____
 State: _____ Zip Code: _____ County: _____ Home Phone: _____
 Job Title: _____
 Work location: _____ Work Phone: _____
 Hepatitis B Vaccinations: Yes No Dates: _____, _____, _____
 Date of last tetanus vaccination: _____ Physician: _____

INCIDENT REPORT

Date of exposure: _____ Time: _____ AM PM
 Location of incident: (Building, room, etc.) _____
 Route(s) of exposure: Eye Nose Mouth Non-intact skin
 Penetration of skin
 Describe what happened: _____

Describe what first-aid was done: (Wash hands, flush mucous membranes, etc.) _____

Employee signature: _____ Date: _____

SOURCE INFORMATION

(Person whose blood contacted employee)

Name: _____ Birthdate: _____
 Address: _____ City: _____
 State: _____ Zip Code: _____ County: _____ Home Phone: _____
 Parent/Guardian (if student): _____
 Hepatitis B Vaccinations: Yes No Dates: _____, _____, _____
 Date of last tetanus vaccination: _____ Physician: _____

**BLOOD EXPOSURE INCIDENT REPORT
SOURCE PERSON INFORMATION**

Name: _____ Birthdate: _____
 Address: _____ City: _____
 State: _____ Zip Code: _____ County: _____ Home Phone: _____
 Parent/Guardian: _____ Work Phone: _____
 Hepatitis B Vaccinations: Yes No Dates: _____, _____, _____
 Date of last tetanus vaccination: _____ Physician: _____

INCIDENT REPORT

An exposure incident, as defined by the Federal and Minnesota State Bloodborne Pathogen Regulations, occurred involving the person listed above.

Date of incident: _____ Time: _____ AM PM

Location of incident: (Building) _____

Brief description: _____

The regulation requires that a sample of blood be drawn as soon as possible from the source of the exposure to determine if any infectious diseases (Hepatitis B, Hepatitis C, and HIV-Human Immunodeficiency Virus) are present. Testing of your/your child's blood would help assist in the treatment and follow up care needed for the exposed individual.

Individuals involved in the exposure are asked to go to the Urgent Care Department, Affiliated Community Medical Center; 101 Willmar Avenue SW; Willmar, MN 56201
 Phone: (320) 214-6922.

For student-to-student exposures it is the financial responsibility of the parent/guardian to pay for blood testing and medical follow-up.

If you decline to permit this testing, your signature of declination is necessary.

I refuse to have my blood (my child's blood) drawn or tested. I understand the Urgent Care Department staff are available for questions at (320) 214-6922.

 Signature (if minor: Parent or Legal Guardian) Date: _____

STUDENT BLOOD EXPOSURE INCIDENT REPORT

Name: _____ Birthdate: _____
 Address: _____ City: _____
 State: ____ Zip Code: _____ County: _____ Home Phone: _____
 Parent/Guardian: _____ Work Phone: _____
 Hepatitis B Vaccinations: Yes No Dates: _____, _____, _____
 Date of last tetanus vaccination: _____ Physician: _____

INCIDENT REPORT

Date of exposure: _____ Time: _____ AM PM

Location of incident: (Building, room, etc.) _____

Route(s) of exposure: Eye(s) Nose Mouth Non-intact skin
Penetration of skin

Describe what happened: _____

Describe what first-aid was done: (Wash hands, flush mucous membranes, etc.) _____

Signature: _____ Date: _____

SOURCE INFORMATION

Hepatitis B Vaccinations: Yes No Dates: _____, _____, _____

Date of last tetanus vaccination: _____ Physician: _____

Individuals involved in exposure are asked to go to the Urgent Care Department, Affiliated Community Medical Center; 101 Willmar, Avenue SW; Willmar, MN 56201 – (320) 214-6922. For student-to-student exposures it is the financial responsibility of the parent/guardian to pay for blood testing and medical follow-up.

EMPLOYEE
POST EXPOSURE DECLINATION OF MEDICAL EVALUATION

**IF THE EXPOSED PERSON CHOOSES NOT TO RECEIVE MEDICAL CARE,
COMPLETE THIS FORM.**

Name: _____

Building: _____ Department: _____

I understand that I have been involved in a workplace encounter with blood or body fluids that may place me at risk for HBV (Hepatitis B virus), HCV (Hepatitis C virus), or HIV (Human Immunodeficiency Virus).

I acknowledge I have been given the opportunity for post-exposure follow-up examination, including testing of my blood for HBV, HCV, and HIV.

I understand that I may obtain this examination through my usual physician. Services provided for me for medical care related to the blood exposure will be at no cost to me. I understand that I am entitled to this examination even though I have been previously vaccinated against HBV.

I have been offered the opportunity to have a sample of my blood drawn and preserved for 90 days in the event that I may choose to have the sample tested at some point within the 90 days.

However, I decline any post-exposure blood sampling, blood testing, or follow-up examination at this time.

Employee Signature: _____

Date: _____