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 CONFIDENTIALLY 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: Call Worker's Compensation Hotline at 1-855-675-3501 and call Human Resources office at 231-8513 to report injury.

D. Students: Complete Student Accident Report form. Call parent/guardian and refer to the Urgent Care Department at Carris Health.

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 Carris Health on the day of the exposure. If parent/guardian refuses to go to the Urgent Care Department at Carris Health have them sign declination statement on bottom of form. In some cases, both individuals may be the 'Source Person'.

F. Individuals involved in exposure are asked to go to the Urgent Care Department, Carris Health; 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 and fax copy of paperwork to the clinic. The family may choose to go to their clinic of choice but Carris Health is encouraged.

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. 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: _____

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: _____

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, Carris Health; 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.

Student
Post Exposure Declination of Medical Evaluation

Student Name: _____ Birthdate: _____

Building: _____

The regulation requires that a sample of blood to 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 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, Carris Health, 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) to be drawn or tested. I understand the Urgent Care Department staff are available for questions at (320) 214-6922.

_____ Date: _____

Signature (if minor: Parent or Legal Guardian)

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, Carris Health; 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.

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