SOUTHERN OREGON HEAD START

1001 Beall Lane * PO Box 3697 * Central Point, OR 97502 * 541-734-5150 * fax: 541-245-9188

EMPLOYEE CONSENT/WAIVER TO PERFORM LABORATORY TESTING

*** Complete, sign, date and return to the Human Resources Department***

On, _____, I was inadvertently exposed to a potentially infectious bodily fluid. In order to assess and to minimize the risks associated with this exposure, I give my consent for my blood to be drawn to detect the presence of any infectious disease(s), including Hepatitis B and HIV. (NOTE: The Center for Disease Control also recommends that testing for Hepatitis C is included in the basic profile.)

CONSENT TO PERFORM LAB TESTING

Results of my lab test may be made available **ONLY** to my personal health care provider.

HCP Name:_____

HCP Address:_____

HCP Phone:_____

Results of the Hepatitis B **ONLY** may be forwarded to the Human Resources Manager at Southern Oregon Child & Family Council, Inc.

Employee Signature _____

Print Name _____ Date _____

----------OR----------

WAIVER TO PERFORM LAB TESTING

I have been offered and have decided to waive my right to be tested for the infectious diseases listed above.

Employee Signature _____

Print Name _____ Date _____