SOUTHERN OREGON HEAD START

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BLOODBORNE PATHOGEN EXPOSURE INCIDENT REPORT

Date of exposure _____ Time _____ Reported by _____

Description of exposure incident (includes route(s) and circumstances of exposure:

_____

_____

_____

Exposed staff member signature _____ date _____

Human Resources signature _____ date _____

SOURCE INDIVIDUAL	EXPOSED STAFF MEMBER
Name	Name
Center	Center
DOB	DOB
Home address	Home address
Parent/Guardian	Home phone
Home phone work phone	Work phone
Hcp name phone	Hcp name phone
Address	Address
Hep B status (if known)	Date referred to hcp
Date/time parent notified	Document sent to hcp (check below)
Consent: Obtained ☐ Refused ☐	☐ Exposed Staff Consent
	☐ Consent for Lab Testing
	☐ HBV Vaccination Record*
FOLLOW UP	**FOLLOW UP**
Health Care Provider Written Opinion Date returned and attached:	Health Care Provider Written Opinion Date returned and attached:

*HBV vaccination record to be provided by employee if not done through SOHS.