SOUTHERN OREGON CHILD & FAMILY COUNCIL

SOURCE INDIVIDUAL HISTORY AND CONSENT

I hereby authorize an exchange of information to occur between the two agencies/health care providers listed below and the exposed individual in accordance with Oregon statue/rules. The staff member's health care provider will discuss results/recommendations with the exposed staff member. I am aware that I, or my child, have been identified as a source individual where a staff member may have been exposed to blood or other potentially infectious body fluids. Southern Oregon Child and Family Council, Inc. will inform the exposed staff member of the source individual's identity.

Southern Oregon Child and Family Council, Inc.
1001 Beall Lane
P O Box 3697
Central Point, OR 97502

Exposed staff member's health care provider

Name _____ Phone # _____

Address _____

_____

I am aware of the risks to the exposed staff member and I have agreed to blood testing to be performed for Hepatitis B and HIV. I have been informed that the blood test results will be released to the exposed staff member, the Human Resources & Safety Manager of Southern Oregon Child and Family Council, Inc., and to the staff member's health care provider.

Name (Print) _____ Date _____

Parent/Guardian signature _____Date _____

HEALTH CARE PROVIDER'S STATEMENT – SOURCE INDIVIDUAL

_____ (health care provider): This person is a source individual of a bloodborne or other potentially infectious body fluid exposure incident. The above named person or the parent/guardian has been notified of the exposure guideline on bloodborne pathogens (OSHA 29 CFR 1910.1030)

Please send the following medical information to Southern Oregon Child & Family Council HR & Safety Manager (mark envelope 'CONFIDENTIAL')

Results of: HbsAG _____ date _____ HIV _____ date _____

Health Care Provider Signature _____ date _____

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