

TO THE PARENTS OF _____ Date: _____

RE: Student /Employee exposure to blood or other potentially infectious material.

Occasionally in the school setting an incident may occur that exposes one person to the blood of other potentially infectious material of another person. This exposure does not mean that an actual disease or illness has been transmitted, but because of the potential we strongly urge you to contact your child's physician today for recommendations.

Nature of exposure: (Names of others involved will not be released without written consent)

_____ Student was exposed to blood or other potentially infectious material of other person. Contact your child's physician immediately for recommendations regarding treatment follow up.

_____ Student's blood or body fluids were the source of exposure to another person.

For medical follow up of this incident we ask that your child's blood be tested for HBV, HIV, and HCV. The attached information more fully explains Hepatitis B, Hepatitis C and AIDS: conditions which blood tests are designed to detect. Please read this information carefully and discuss it with your child's physician. You may decline to have your child's blood tested.

Date: _____ Time: _____

Signature of Person Completing Form

The 'NAME' School nurse may be contacted if your physician requests any further information regarding this incident.

I, _____, have discussed this incident with my child's
(Name of Parent)
physician and have reviewed the information on this form and the attached information regarding
Hepatitis B, Hepatitis C and AIDS. I have decided:

_____ Not to have my child's blood tested for HBV, HCV, and or HIV.

_____ To have my child's blood tested for HBV, HCV, and or HIV, to have results along with
child's name and date of birth given to the other person and/or his/her physician.

I agree to release any information in my child's medical record pertinent to this situation to the
other person (s) physician if needed in order to determine necessary treatment.

_____ Yes _____ No

Name of child _____

DOB _____

Child's Physician _____

Date of appointment _____

Signature of Parent _____ Date _____

(Please return this form to the St Cloud School District Nurse on the following day in the postage
paid envelope provided)