Bloodborne Pathogen Post-Exposure Medical Evaluation

Please complete and return form to:
Arrowhead Head Start; Attn: Health Manager
702 3rd Avenue South, Virginia, MN 55792
Fax: 218-749-2944

Employee Name: ____

Due to a possible bloodborne pathogen exposure in the workplace and OSHA protocol, I allow this health information to be released to Arrowhead Head Start.

Employee Signature:______________________________Date: ______________

Dear Health Care Provider: This employee has been referred to you for a medical evaluation due to a potential bloodborne pathogen exposure. Please complete this form and return it to Arrowhead Head Start within 15 days of the exam. If you need further information for proper evaluation, contact the Head Start Health Manager at (218) 748-7317. Thank you!

Date and Time of Incident: ______________________________________

Type of Exposure: ☐ cut with sharp object

☐ blood or other body fluid on skin/mucous membrane

☐ needle stick

☐ other (specify): ______________________________

Date and Time Employee Was Evaluated: ____________________________

Based on my evaluation, this employee should receive the Hepatitis B vaccine:

☐ Yes; date the first injection was given: __________________________

☐ No

☐ Employee has previously received this vaccine **or** has medically-confirmed history of disease

Has the employee been informed about the results of this post-exposure evaluation? ☐ Yes ☐ No

Has the employee been informed about any potential medical conditions resulting from this exposure that may require further evaluation or treatment? ☐ Yes ☐ No

Other comments or relevant information: ______________________________

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Health Care Provider Signature: _________________________ **Date:** ______________

Provider Name: ____

Facility Address: ____

4-2017