

**The College of Southern Idaho Paramedic Programs  
Health Hazard Exposure Form**

**Student Information**

Name \_\_\_\_\_ SSN \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
 Class \_\_\_\_\_ Course Number \_\_\_\_\_ Work Phone \_\_\_\_\_

**Exposure Information**

Date \_\_\_\_\_ Call/Patient # \_\_\_\_\_  
 Location \_\_\_\_\_

Were you exposed to blood, body fluids, or other potentially infectious materials?  No  Yes  
 Source Individual (Patient, Client, Prisoner, Unknown, etc.) \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_  
 Disposition of Source Individual (Hospitalized, Incarcerated, Ambulance etc.) \_\_\_\_\_

Was Screening of Source Individual Requested?  No  Yes To Whom did you Make Request? \_\_\_\_\_

**Methods of Exposure**

Inhalation  Ingestion  Absorption  Injection  Unknown

**Communicable Disease**

HIV/AIDS  Chickenpox  Hepatitis B  Herpes  Measles  
 Meningitis  Mumps  Syphilis/Gonorrhea  Tuberculosis  Other

**Hazardous Materials**

Identify \_\_\_\_\_

**Level of Treatment**

None  At Scene  Panel Physician  Hospital  Public Health  Other

**Personal Protective Equipment**

None  Gloves  Mask  Eye Protection  Gown/Apron  Other

**Description of Incident**

\_\_\_\_\_

Was anyone else exposed?  No  Yes If yes, Please complete

Name \_\_\_\_\_ Dept. \_\_\_\_\_ Position \_\_\_\_\_  
 Name \_\_\_\_\_ Dept \_\_\_\_\_ Position \_\_\_\_\_

**-For Medical Use Only-**

<b><u>Test Results of Source Individual</u></b>	<b><u>Student Treatment</u></b>
<input type="checkbox"/> Source Unknown <input type="checkbox"/> Denied Consent HIV <input type="checkbox"/> Neg. <input type="checkbox"/> Pos Date _____ HBV <input type="checkbox"/> Neg. <input type="checkbox"/> Pos Date _____ Meningitis <input type="checkbox"/> Neg. <input type="checkbox"/> Pos Date _____ TB <input type="checkbox"/> Neg. <input type="checkbox"/> Pos Date _____	<input type="checkbox"/> HIV Screening Dates Baseline _____ 2 <sup>nd</sup> _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Pos. 3 <sup>rd</sup> _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Pos. 4 <sup>th</sup> _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Pos.
<p align="center"><b><u>Counseling</u></b></p> Student Informed of Results Date _____ Person Performing Counseling Init. _____ Employee Offered Treatment Date _____ Person Performing counseling Init _____ Student Informed of Ramifications Date _____ Person Performing Counseling Init _____ Physician's Name _____ Signature _____	<input type="checkbox"/> Hepatitis B Vaccine Dates 1 <sup>st</sup> _____ HbsAb Date _____ 2 <sup>nd</sup> _____ Result _____ 3 <sup>rd</sup> _____ Series Completed _____ Booster _____ <input type="checkbox"/> Immune Globulin (HBIG) Date _____ <input type="checkbox"/> Meningitis Medication _____ Date _____ <input type="checkbox"/> Tuberculosis <input type="checkbox"/> PPD Date _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Pos. Date _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Pos. <input type="checkbox"/> X-Ray Date _____ <input type="checkbox"/> Neg. <input type="checkbox"/> Pos. <input type="checkbox"/> INH Date _____ <input type="checkbox"/> Other _____

