



ST. MARY'S COUNTY PUBLIC SCHOOLS
DEPARTMENT OF HUMAN RESOURCES
DEPARTMENT OF STUDENT SERVICES

EXPOSURE INCIDENT PACKET

This packet contains the following documents:

1. Bloodborne Pathogen Post-Exposure Protocol
2. Procedure for Post-Exposure Management Occupational Exposure Checklist
3. Form: Employee Report of Exposure Incident
4. Form: Worker's Compensation Reporting Forms: Employee's Statement of Accident/Injury/Illness and Supervisor's Incident Report (online at <https://www.smcps.org/offices/fiscal-services/employeeforms>) Forms are located under: Employee Injury folder
5. Form: Site Administrator's/Supervisor's Investigation of Exposure Incident
6. Form: Employee Consent/Declination for Post-Exposure Medical Evaluation and Treatment
7. Form: Post-Exposure Referral to Medical Consultant
8. Form: Employee Exposure Medical Evaluation
9. Form: Source Identification and Medical Evaluation
10. Form: Source Individual's Consent or Refusal For Blood Testing
11. Form: PS 100 – Student Record Release

Hepatitis B Forms for Employees:

1. Form: Hepatitis B Vaccination Consent/Declination
2. Form: St. Mary's County Vaccine Administration Record – Adolescents/Adults
3. Vaccine Information Statement: Hepatitis B Vaccine – *What you Need to Know*

Employee medical records must be kept confidential in accordance with OSHA regulation 29 CFR 1910.1030.



ST. MARY'S COUNTY PUBLIC SCHOOLS
DEPARTMENT OF HUMAN RESOURCES

BLOODBORNE PATHOGEN POST-EXPOSURE PROTOCOL

“Exposure” definition:

1. Blood contact with the mucous membrane of the eye, nose, or mouth; or
2. Blood contact with broken skin, including dermatitis; or
3. Penetration of skin with blood-contaminated sharp (needle, lancet, glass, human bite)
4. Other body fluids may also be considered an exposure. If in doubt, ask your administrator/supervisor or the school nurse.

In the event of an exposure incident, it is very important to follow this post-exposure protocol and obtain a medical evaluation *immediately* (within 24 hours). Time is important in providing the most comprehensive and protective treatment.

Exposed Employee Should:

1. **Immediately wash the exposed** area or flush mucous membrane with running water for at least **15 minutes**.
2. Contact your administrator/supervisor or school nurse.
3. Take the completed forms packet with you (if possible) to the medical evaluation.

REMINDER:

Make copies of completed forms before assembling packet for physician/healthcare professional.

4. Send copies of completed forms to the Coordinator of Benefits in the Department of Fiscal Services for follow-up and confidential record maintenance.



ST. MARY'S COUNTY PUBLIC SCHOOLS

BLOODBORNE PATHOGEN STANDARD: OCCUPATIONAL EXPOSURE CHECKLIST

(29 CFR 1910.1030)

Procedure for Post-Exposure Management

Refer to SMCPs Exposure Control Plan

Task	Date/Time/Initials	To be performed by
1. Administer first aid and wound exposure management. With skin exposure: wash the affected area well with soap and water. If the wound is bleeding, allow it to bleed. Rinse thoroughly and allow the air to dry. Mucus membrane exposure: Flush the exposed area well with water for 15 minutes.		Staff member to be assisted by the school nurse or designated CPR/First Aid trained staff member.
2. Report immediately to the principal or site supervisor.		Potentially Exposed Employee
3. Document the incident immediately and complete: a) Employee Report of Exposure Incident Form b) Employee's Statement of Accident/Injury/Illness (Online) c) Supervisor's Incident Report (Online) d) Site Administrator's/Supervisor's Investigation of Exposed Incident Form		a) Employee and School Nurse b) Employee c) Site Administrator/Supervisor d) Site Administrator/Supervisor/Designee
4. Complete Employee Consent/Declination for Post Exposure Medical Evaluation and Treatment Form.		Employee
5. Refer the employee for treatment immediately. (Staff member needs to be seen and treated at the closest ER preferably within 24 hours of the incident.) a) Complete the "Post Exposure Referral to Medical Consultant" form and attach a copy of the Bloodborne Pathogen Standard. b) Send the employee to St. Mary's Hospital Emergency Room along with the following forms: Employee Exposure Medical Evaluation Form, the Post-Exposure Medical Evaluation and Treatment form, and the completed Employee Consent/Declination for Post-Exposure Medical Evaluation and Treatment form		Site Administrator/Supervisor or Designee Site Administrator/Supervisor or Designee/Employee Site Administrator/Supervisor or Designee

BLOODBORNE PATHOGEN STANDARD: OCCUPATIONAL EXPOSURE CHECKLIST, CONTINUED

6. Interview and refer source individual: a) Interview source individual, if source individual is a minor, contact the parent/ legal guardian and request cooperation in obtaining blood testing for HIV and Hepatitis B and Hepatitis C. b) If the source individual agrees to testing, refer the individual to the physician of personal choice or to the emergency room. Complete the top portion of the form "Source Identification and Medical Evaluation and Testing" form and send it with the source individual. c) Have the source individual, or if a minor, parent/legal guardian complete "Source Individual Consent or Refusal for Blood Testing." d) If a minor, parent(s)/legal guardian(s) must complete PS 100 – Student Record Release to share with St. Mary's County Public Schools, Office of Human Resources.	 	Site Administrator/Supervisor *School Nurse supports administrator discussion with parent(s)/legal guardian(s) Site Administrator/Supervisor or designee Parent(s)/Legal Guardian(s) Parent(s)/Legal Guardian(s) *School Nurse completes the written exchange of information and types of medical records sections
7. Recordkeeping: All records required by the Bloodborne Pathogen Standard for employees with occupational exposure will be maintained by the Department of Human Resources for the duration of employment plus 30 years.	 	Sent by site administrator/supervisor/kept by Human Resources Office of St. Mary's County Public Schools
8. Report and subsequent illness that result from the exposure incident to the health department, if reportable under COMAR 10.06.01. Any incident that received more than minor emergency treatment or results in subsequent illness must be added to any required MOSH injury and illness log (OSHA 200 form).	 	Department of Human Resources



**St. Mary's County Public Schools
Employee Report of Exposure Incident**

CONFIDENTIAL

Take this completed form to your medical facility.

TO BE COMPLETED BY EMPLOYEE:

Name: _____ Date of Birth: _____

Date of Exposure: _____ Time of Exposure: _____

School/Location: _____

Name of suspected exposed worker: _____ ID#: _____

Job Title: _____ Location where exposure occurred: _____

Type of Exposure: (check all that apply)

_____ Percutaneous (needle or sharp object that was in contact with blood or body fluids)

_____ Mucus Membrane

_____ Skin (Circle one: intact non-intact unsure/unknown)

_____ Bite (that broke the skin)

Exposure and Source Information

1. Type of fluid or material (check all that apply)

- _____ Blood
- _____ Visible bloody body fluid*
- _____ Non-visible bloody body fluid*
- _____ Visible bloody solution (e.g., water used to clean a blood spill)

***identify which body fluid:**

___ Urine ___ Feces/Stool
___ Sputum ___ other specify:
___ Saliva ___ Unknown

2. Body site of exposure: _____

3. If percutaneous exposure: Depth of injury

- _____ Superficial (e.g., scratch, no or little blood)
- _____ Moderate (e.g., penetrated through skin, wound bled)
- _____ Deep (e.g., intramuscular)
- _____ Unsure/Unknown

4. If mucous membrane or skin exposure, approximate volume of material:

_____ Small (e.g., few drops)
_____ Large (e.g., major blood splash)

Source Information:

Name: _____

Address: _____

Cell #: _____ Home #: _____ Work #: _____

5. Hepatitis B Vaccination Status (if known):

Any previous Hepatitis Vaccinations? Yes _____ No _____

Date(s): (1) _____ (2) _____ (3) _____

6. Description of Duties (related to incident):

7. Task being performed at the time of exposure:

Employee Narrative

(Explain how exposure occurred)

8. Information on source individual, if available (person whose blood contacted

employee) Name: _____

Is source HIV positive? Yes _____ No _____ Don't Know _____

Is source Hepatitis B positive? Yes _____ No _____ Don't Know _____

Did source consent to blood testing for HBV and HIV? Yes _____ No _____

If yes, where and when will the test be done? (Record test date, name, address, and phone number of medical provider below.)

Date test will be done: _____ Medical Provider: _____

Address: _____ Phone Number: _____

Employee's Signature: _____ Date: _____

Administrator's/Supervisor's Signature: _____

Date: _____

To be completed by the employee

Copy to: Department of Human Resources within 24 hours

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ST. MARY'S COUNTY PUBLIC SCHOOLS
Department of Human Resources

**SITE ADMINISTRATORS/SUPERVISORS/DESIGNEE
 INVESTIGATION OF EXPOSURE INCIDENT FORM**

Administrator/Supervisor Completes:

Completed by: _____ Date: _____ Time: _____

School: _____

Name: _____

I.D.#:

Job Title: _____

1. Attach a copy of "Employee Report of Exposure Incident" form.

2. Describe the exposure incident.

3. Personal protective equipment in use at time of incident. (check all that apply)

☐ Gloves	☐ Gown or Other Protective Clothing
☐ Mask	☐ Face Shield
☐ Goggles	☐ Other (specify) _____

4. Personal protective equipment required by policy for the task being performed at time of incident. (check all that apply)

☐ Gloves	☐ Gown or Other Protective Clothing
☐ Mask	☐ Face Shield
☐ Goggles	☐ Other (specify) _____

5. Condition of personal protective equipment at time of incident: (check all that apply)

	Gloves	Mask	Face Shield	Goggles	Grown/Apron	Other
Good						
Fair						
Poor						
Other						

*SITE ADMINISTRATOR/SUPERVISORS/DESIGNEE INVESTIGATION OF EXPOSURE INCIDENT FORM
(CONTINUED) Page 2 of 2*

6. Describe any defects in items checked fair or poor.

7. Tools/Engineering equipment in use at the time of incident: (check all that apply and note condition)

Equipment	In Use?		Condition of Equipment			Other
	Yes	No	Good	Fair	Poor	
Needle Shield						
Sharps Container						
Biosafety Hood						
Splash Shield						

8. Describe any defects in personal protective equipment in fair or poor condition.

9. Recommendations to prevent similar exposure incidents.

Name (print) _____ Date _____

Signature _____

Phone _____

Copy to: Department of Human Resources



ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Human Resources

*EMPLOYEE CONSENT/DECLINATION FOR
POST-EXPOSURE MEDICAL EVALUATION AND TREATMENT*

Confidential

**Take to
Medical Facility**

After a suspected Exposure to Blood or other OPIM (Other potentially infectious material) as determined by the Employee Exposure Determination Form.

Statement of Understanding:

I have received training and understand the SMCPS' Exposure Control Plan. I was exposed to blood and other potentially infectious body fluids at my worksite on _____ (date). As a result of this incident, I have completed the required incident report and have been advised by administration to seek medical evaluation and treatment to determine potential exposure to HIV, HCV, or HBV, as soon as possible of the exposure incident, at no charge to me.

Employee's Last Name:	Employee's First Name:
Job Title:	ID#:
Work Site Name:	
Work Site Address:	
Home Phone #:	Work Phone #:

- You may consent to have the blood drawn and tested immediately.
- You may refuse to have your blood tested.
- You may elect to have the blood drawn, but not tested, with the option to have the blood preserved for at least 90 days. You may elect to have the preserved sample tested anytime within those 90 days.

EMPLOYEE CONSENT/DECLINATION FOR POST-EXPOSURE MEDICAL EVALUATION AND TREATMENT (CONTINUED)

1. **Consent:** I consent to and authorize testing of my blood for human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV).

Signed: _____ Date: _____

2. **Refusal:** I refuse to have my blood drawn or tested.

Signed: _____ Date: _____

Limited Consent: I consent having a baseline blood sample drawn and preserved. I understand that anytime within 90 days I may elect to have this sample tested or destroyed without being tested.

Signed: _____ Date: _____

Copy to: Department of Human Resources (**within 24 hours**)

May 2025 - Employee Consent/Declination for Post-Exposure Medical Evaluation and Treatment



ST. MARY'S COUNTY PUBLIC SCHOOLS

Department of Human Resources

POST-EXPOSURE REFERRAL TO MEDICAL CONSULTANT

This employee is referred following an exposure incident to blood or other infectious material. Please complete and return the attached Report of Evaluation by the Medical Consultant.

Employee Name: _____ Employee Position: _____

Attach Bloodborne Pathogen Standard: Date: _____ Time: _____

1. Employee's duties which relate to incident: (check all that apply)

- _____ Handles needles or other sharps
- _____ Performs wound care
- _____ Performs first responder care/CPR
- _____ Handles medical waste
- _____ Restrains assaultive clients
- _____ Other: _____

2. Route of Exposure:

- _____ Needle stick
- _____ Puncture wound from other sharp
- _____ Non-intact skin exposure
- _____ Splash/splatter of mucous membrane
- _____ Bite that broke the skin
- _____ Other: _____

3. Type of body fluid involved:

- _____ Blood
- _____ Other: _____

4. Describe exposure:

5. Knowledge of source of exposure (Circle):

HIV Status: Positive ☐ Negative Unknown ☐

HBsAG Status: Positive Negative Unknown

POST-EXPOSURE REFERRAL TO MEDICAL CONSULTANT (CONTINUED)

6. Employee's history of Hepatitis B immunization:

First Dose: _____ Second Dose: _____ Third Dose: _____
Date Date Date

Booster Dose(s): _____
Date

Result of antibody testing:

Date Result

7. Other relevant medical history:

_____ Adverse effects to HB Vaccine: _____
_____ History of yeast allergy
_____ Other: _____

8. Copy of OSHA Bloodborne Pathogen Standard enclosed?

_____ Yes
_____ No

Date Site Administrator's/Supervisor's Signature Phone

Completed by: Site Administrator/Supervisor/Designee/Employee
Copy to: Department of Human Resources



ST. MARY'S COUNTY PUBLIC SCHOOLS
Department of Human Resources

Bloodborne Pathogens Standard
 29 CFR 1910.1030

Confidential

**Take to
 Medical Facility**

EMPLOYEE EXPOSURE MEDICAL EVALUATION FORM

As required under the OSHA Bloodborne Pathogens Standard, 29 CFR 1910.1030, the above employee is seeking a medical evaluation because of an exposure to blood or other potentially infectious body fluid.

The following information is provided for your reference:

- A copy of the OSHA Bloodborne Pathogens standard;
- Exposure incident forms, including:
 - A description of the exposed employee's duties as they relate to the exposure incident documentation of the route(s) of exposure and circumstances under which exposure occurred;
 - Employee Consent/Declination for Post-Exposure Medical Evaluation and Treatment; and
 - A summary of the employee's vaccination status, if known.

EXPOSED EMPLOYEE			
Employee's Last Name:		Employee's First Name:	
D.O.B.:		Employee ID #:	
Worksite Name:		Work Phone #:	
MEDICAL CARE PROVIDER			
Health Care Professional Name:		Title:	
Location:			
Phone #:		Fax #:	
MEDICAL CARE PROVIDER'S REPORT WRITTEN OPINION			
Was Hepatitis B vaccination indicated?		☐ Yes ☐ No	Provided? ☐ Yes ☐ No
Was Hepatitis Immune Globulin (HBIG) indicated?		☐ Yes ☐ No	Provided? ☐ Yes ☐ No
Was the exposed employee informed of the current results of this evaluation?		☐ Yes ☐ No	
Was the exposed employee informed regarding medical conditions resulting from exposure to blood/potentially infectious materials which may require further evaluation or treatment? ☐ Yes ☐ No			
HIV Testing Results:		☐ Yes ☐ No	Date: _____
HBV Testing Results:		☐ Yes ☐ No	Date: _____
HCV Testing Results:		☐ Yes ☐ No	Date: _____
Other Pertinent Information:			

This form and related documentation will be kept on file at SMCPs for the length of employment and 30 years. This form and related documentation will remain confidential. Personal identifying information

will be released with the employee's consent only.

EMPLOYEE EXPOSURE MEDICAL EVALUATION FORM (CONTINUED)

Return this form within 15 days to the Department of Human Resources, **St. Mary's County Public Schools**, 23160 Moakley Street, Suite 106, Leonardtown, Maryland 20650.

NOTE: OSHA's Bloodborne Pathogens Standard cited as 29 CFR 1910.1030 requires that post-exposure counseling be given to employees following an exposure incident. Counseling should include United States Public Health Services (USPHS) recommendations for transmission and prevention of HIV. In addition, counseling must be made available regardless of the employee's decision to accept serological testing.

Has the patient/employee been counseled in the transmission and prevention of HIV? _____ Yes _____ No

Signature of Medical Care Provider/Counselor

Date

Completed by: Medical Professional



ST. MARY'S COUNTY PUBLIC SCHOOLS

*Department of Student Services
Department of Human Resources*

Bloodborne Pathogens Standard
29 CFR 1910.1030

SOURCE IDENTIFICATION AND MEDICAL EVALUATION FORM

Confidential

**Take to
Medical Facility**

Source's Last Name: _____ Source's First Name: _____

Source's Address: _____ Parent/Legal Guardian Name: _____

SOURCE		
Source's Title:	Source's Home #:	
MEDICAL CARE PROVIDER		
Health Care Professional Name:		
Location:		
Phone #:	Fax #:	
Date of Incident:		
Did you treat the patient directly? ☐ Yes ☐ No		
HIV Testing Results: ☐ Yes ☐ No Date:		
HBV Testing Results: ☐ Yes ☐ No Date:		
HCV Testing Results: ☐ Yes ☐ No Date:		
Other Pertinent Information:		

This form and related documentation will be kept on file at SMCPS for the length of employment and 30 years. This form and related documentation will remain confidential. Personal identifying information will be released with the source's, or if a minor, parent/legal guardian's consent only.

Return this form within 15 days to the Department of Human Resources, **St. Mary's County Public Schools**, 23160 Moakley Street, Suite 106, Leonardtown, Maryland 20650.

Has the patient/source been counseled in the transmission and prevention of HIV? _____ Yes _____
No

Signature of Medical Care Provider/Counselor

Date

Completed by: Medical Professional
Copy to: Department of Human Resources



ST. MARY'S COUNTY PUBLIC SCHOOLS
Department of Student Services
Department of Human Resources

Confidential

SOURCE INDIVIDUAL'S
CONSENT OR REFUSAL FOR BLOOD TESTING

Instructions:

Source individual (or their parent/legal guardian, if source individual is a minor) to complete this form for consent/decline of blood testing.

To the source individual:

A SMCPS employee was accidentally exposed to your blood/your child's blood. This could be an infection risk to the exposed individual. Test of your/your child's blood would help assist in the treatment and follow-up care needed for the exposed individual.

The district is requesting this testing to comply with OSHA Regulation 29 CFR 1910.1030, Bloodborne Pathogens, which requires testing of the source individual's blood for Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C (HCV) after consent is obtained. If you refuse to permit this testing, your signature of declination is necessary.

Your assistance will be greatly appreciated.

Source Individual's Name: _____

Parent/Legal Guardian Name if Source is a Minor: _____

Please sign only **one** of the options below:

1. **Consent:** I consent to and authorize testing of my blood (my child's blood) for Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV).

Signed: _____ Date: _____

2. **Refusal:** I refuse to have my blood (my child's blood) drawn or tested.

Signed: _____ Date: _____

3. **No need to test (circle appropriate information):** I am (my child is known to be) HIV (and/or HBV, HCV) positive.

Signed: _____ Date: _____

Return this form within 15 days to the Department of Human Resources, 23160 Moakley Street, Suite 106, Leonardtown, Maryland 20650



ST. MARY'S COUNTY PUBLIC SCHOOLS
Department of Human Resources

HEPATITIS B VACCINATION CONSENT/DECLINATION FORM

Option A: I understand the benefits and risks of Hepatitis B vaccination. I understand that I must receive at least 3 intramuscular doses of vaccine in the arm over a 6-month period to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I do understand that anyone with a known allergy to yeast should not accept this vaccine. Hepatitis B vaccine will be made available at no charge to employees having occupational blood exposure. I have had an opportunity to ask questions, and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent. I understand that participation is voluntary.

I desire that my employer provide the required Hepatitis B vaccine.

Print Name

Social Security Number/Employee ID#

Date

Signature

Assignment: _____

Option B: I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Date

Signature

Option C: If you have already had the Hepatitis B vaccine series, then you do not need another vaccine. Please fill out the following information:

I have received the Hepatitis B vaccination on:

1st Dose

2nd Dose

3rd Dose

Print Name

Social Security/Employee ID#

Date

Signature

Send completed form to the Department of Human Resources. Employees requesting the vaccination will be directed to St. Mary's Marathon Health Center.